Filing at a Glance

Company:	MedMal Direct Insurance Company
Product Name:	MMDIC IL Initial Rates Filing
State:	Illinois
TOI:	11.2 Med Mal-Claims Made Only
Sub-TOI:	11.2023 Physicians & Surgeons
Filing Type:	Rate/Rule
Date Submitted:	01/15/2014
SERFF Tr Num:	MERL-129004724
SERFF Status:	Closed-Filed
State Tr Num:	
State Status:	Under Review
Co Tr Num:	MERL-129004724
Effective Date Requested (New):	On Approval
Effective Date Requested (Renewal):	On Approval
Author(s):	Deb Hamilton
Reviewer(s):	Gayle Neuman (primary), Caryn Carmean, Julie Rachford
Disposition Date:	05/12/2014
Disposition Status:	Filed
Effective Date (New):	01/15/2014
Effective Date (Renewal):	01/15/2014

State Filing Description:
routed 3/27/14

State: Illinois **Filing Company:** MedMal Direct Insurance Company
TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons
Product Name: MMDIC IL Initial Rates Filing
Project Name/Number: /

General Information

Project Name:
Project Number:
Reference Organization:
Reference Title:
Filing Status Changed: 05/12/2014
State Status Changed: 03/27/2014
Created By: Deb Hamilton
Corresponding Filing Tracking Number:

Status of Filing in Domicile: Not Filed
Domicile Status Comments:
Reference Number:
Advisory Org. Circular:

Deemer Date:
Submitted By: Deb Hamilton

Filing Description:

This is the initial filing of rates and rules for MedMal Direct Insurance Company (MMDIC) for their new Illinois Physicians & Surgeons Professional Liability Program. The proposed effective date is 1/15/2014. MMDIC intends to write new business in this program.

Company and Contact

Filing Contact Information

Meg Glenn, Consulting Actuary
3274-B Medlock Bridge Rd.
Norcross, GA 30092

mglenn@merlinosinc.com
678-684-4859 [Phone]

Filing Company Information

(This filing was made by a third party - merlinosandassociatesincorporated)

MedMal Direct Insurance Company
245 Riverside Ave.
Suite 550
Jacksonville, FL 32202
(904) 482-4068 ext. [Phone]

CoCode: 13793
Group Code:
Group Name:
FEIN Number: 27-2813188

State of Domicile: Florida
Company Type:
State ID Number:

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

State Specific

Refer to our checklists prior to submitting filing (http://www.idfpr.com/DOI/Prop_Cas_IS3_Checklists/IS3_Checklists.htm).: Comply
Refer to our updated (04/06/2007) SERFF General Instructions prior to submitting filing. They have been updated to clarify what rates and rules are required to be filed as well as what rates and rules are not required to be filed. Also, the "Product Name" is the Filing Title and not the Project Number.: Comply
NO RATES and/or RULES ARE REQUIRED TO BE FILED FOR LINES OF COVERAGE SUCH AS COMMERCIAL AUTO (except taxicabs), BURGLARY AND THEFT, GLASS, FIDELITY, SURETY, COMMERCIAL GENERAL LIABLITY, CROP HAIL, COMMERCIAL PROPERTY, DIRECTORS AND OFFICERS, ERRORS AND OMMISSIONS, COMMERCIAL MULTI PERIL just to mention a few. However, a Summary Sheet (RF-3) is required to be filed. Please refer to the State Specific Field

below for what rates/rules are required to be filed and to our checklists for specific statutes, regulations, etc. : http://insurance.illinois.gov/Prop_Cas_IS3_Checklists/IS3_Checklists.asp .: Compy
Medical Malpractice rates/rules may now be submitted using SERFF effective January 1, 2012.: Comply
The only rates and/or rules that are required to be filed are Homeowners, Mobile Homeowners, Dwelling Fire and Allied Lines, Workers' Compensation, Liquor Liability, Private Passenger Automobiles, Taxicabs, Motorcycles and Group Inland Marine Insurance which only applies to insurance involving personal property owned by, being purchased by or pledged as collateral by individuals, and not used in any business, trade or profession per Regulation Part 2302 which says in part, "each company shall file with the Director of Insurance each rate, rule and minimum premium before it is used in the State of Illinois.": Comply
When selecting a form filing type for a multiple form filing, use the dominant type from these choices: APP - application; CER - certificate; COF - coverage form; DPS - declaration page; END - endorsement; POJ - policy jacket; ORG - Companies adopting an Advisory or Rating Organization's filing. Example: If you are submitting a policy as well as endorsements, a declaration page and an application, you would select "POL" for policy.: N/A

SERFF Tracking #:	*MERL-129004724*	***State Tracking #:***		***Company Tracking #:***	*MERL-129004724*

State:	*Illinois*	***Filing Company:***	*MedMal Direct Insurance Company*
TOI/Sub-TOI:	*11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons*		
Product Name:	*MMDIC IL Initial Rates Filing*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Filed	Gayle Neuman	05/12/2014	05/12/2014

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Gayle Neuman	03/21/2014	03/24/2014
Pending Industry Response	Gayle Neuman	01/27/2014	01/27/2014

Response Letters

Responded By	Created On	Date Submitted
Deb Hamilton	03/27/2014	03/27/2014
Deb Hamilton	02/10/2014	02/10/2014

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Effective Date	Note To Reviewer	Deb Hamilton	05/12/2014	05/12/2014
effective date - 2nd request	Note To Filer	Gayle Neuman	05/09/2014	05/09/2014
effective date	Note To Filer	Gayle Neuman	05/02/2014	05/02/2014
Actuarial Review	Reviewer Note	Caryn Carmean	05/01/2014	

SERFF Tracking #:	*MERL-129004724*	***State Tracking #:***		***Company Tracking #:***	*MERL-129004724*

State:	*Illinois*	***Filing Company:***	*MedMal Direct Insurance Company*
TOI/Sub-TOI:	*11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons*		
Product Name:	*MMDIC IL Initial Rates Filing*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 05/12/2014

Effective Date (New): 01/15/2014

Effective Date (Renewal): 01/15/2014

Status: Filed

Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	Number of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
MedMal Direct Insurance Company	%	%				%	%

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Explanatory Memorandum		Yes
Supporting Document	Form RF3 - (Summary Sheet)		Yes
Supporting Document	Certification		Yes
Supporting Document (revised)	Manual		Yes
Supporting Document	Manual		Yes
Supporting Document	Request to Maintain Data as Trade Secret Information		Yes

State: Illinois **Filing Company:** MedMal Direct Insurance Company
TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons
Product Name: MMDIC IL Initial Rates Filing
Project Name/Number: /

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	03/21/2014
Submitted Date	03/24/2014
Respond By Date	04/07/2014

Dear Meg Glenn,

Introduction:

This is to acknowledge receipt of your filing. Your submission is not acceptable for filing in Illinois due to the following reasons:

1. Pursuant to 215 ILCS 5/143.16, all notices of cancellation issued during the first 60 days of coverage must be mailed at least 30 days prior to the effective date of cancellation, unless cancellation is for nonpayment of premium which requires at least 10 days prior notice. After the coverage has been in effect for over 60 days, all notices must be mailed at least 60 days prior to the effective date of cancellation unless cancellation is for nonpayment of premium.

2. After a policy has been issued and the initial payment is received and accepted, failure to pay premium does not void a policy.

3. Please explain the locum tenens policy. Why would a separate policy have to be issued for the locum tenen - just to be cancelled? Why isn't the endorsment for the physician for such coverage enough?

4. In regard to the retrospective rating plan, is the $1,000,000 premium for medical malpractice alone - not including general liability? In regard to the cancellation of the policy with the retrospective rating plan, the term "null and void" should be rephrased to indicate it will just no longer apply.

5. Under Defense Costs, pursuant to 215 ILCS 5/143 (2), defense costs must be paid as supplement to the limits of liability.

6. Pursuant to Company Bulletin 2011-05, the schedule rating plan cannot exceed a credit or debit of 25%.

7. Where are the rates? I only see discounts, factors, and aggregates.

Conclusion:

Sign up to get e-mail notification for updates to the Department's website. http://insurance.illinois.gov/RSS/

Please refer to the appropriate Property Casualty IS3 Review Requirements Checklist before submitting any filing. The checklists are available at the Department's Web site or at the following link:

http://insurance.illinois.gov/Prop_Cas_IS3_Checklists/IS3_Checklists.asp

Please submit compliant form(s) no later than the date shown above or the entire filing may be disapproved. Please be advised that when the Director disapproves the form(s) you must immediately cease using the form(s) in Illinois.

Please give this matter your immediate attention. If you have any question regarding this filing please feel free to contact me.

Sincerely,

Gayle Neuman

State: Illinois **Filing Company:** MedMal Direct Insurance Company
TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons
Product Name: MMDIC IL Initial Rates Filing
Project Name/Number: /

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	01/27/2014
Submitted Date	01/27/2014
Respond By Date	01/31/2014

Dear Meg Glenn,

Introduction:

This is to acknowledge receipt of your filing. Your submission is not acceptable for filing in Illinois due to the following reasons:

You previously requested an effective date of January 15, 2014. Because the company is still not licensed to date, the filing should either be withdrawn or the effective date should be revised.

Conclusion:

Sign up to get e-mail notification for updates to the Department's website. http://insurance.illinois.gov/RSS/

Please refer to the appropriate Property Casualty IS3 Review Requirements Checklist before submitting any filing. The checklists are available at the Department's Web site or at the following link:

http://insurance.illinois.gov/Prop_Cas_IS3_Checklists/IS3_Checklists.asp

Please submit compliant form(s) no later than the date shown above or the entire filing may be disapproved. Please be advised that when the Director disapproves the form(s) you must immediately cease using the form(s) in Illinois.

Please give this matter your immediate attention. If you have any question regarding this filing please feel free to contact me.

Sincerely,

Gayle Neuman

SERFF Tracking #:	*MERL-129004724*	***State Tracking #:***		***Company Tracking #:***	*MERL-129004724*

State:	*Illinois*	***Filing Company:***	*MedMal Direct Insurance Company*
TOI/Sub-TOI:	*11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons*		
Product Name:	*MMDIC IL Initial Rates Filing*		
Project Name/Number:	*/*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	03/27/2014
Submitted Date	03/27/2014

Dear Gayle Neuman,

Introduction:

Please see our responses below:

Response 1

Comments:

SERFF Tracking #:	MERL-129004724	**State Tracking #:**		**Company Tracking #:**	MERL-129004724

State:	Illinois	**Filing Company:**	MedMal Direct Insurance Company
TOI/Sub-TOI:	11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons		
Product Name:	MMDIC IL Initial Rates Filing		
Project Name/Number:	/		

1. Pursuant to 215 ILCS 5/143.16, all notices of cancellation issued during the first 60 days of coverage must be mailed at least 30 days prior to the effective date of cancellation, unless cancellation is for nonpayment of premium which requires at least 10 days prior notice. After the coverage has been in effect for over 60 days, all notices must be mailed at least 60 days prior to the effective date of cancellation unless cancellation is for nonpayment of premium.

We have revised page 3-U of the Underwriting Rates and Rules Manual - Illinois to comply with 215 ILCS 5/143.16. Please see updates in the redlined and revised manual attached to this response.

2. After a policy has been issued and the initial payment is received and accepted, failure to pay premium does not void a policy.

We have revised page 3-U of the Underwriting Rates and Rules Manual - Illinois to clarify. Please see updates in the redlined and revised manual attached to this response.

3. Please explain the locum tenens policy. Why would a separate policy have to be issued for the locum tenen - just to be cancelled? Why isn't the endorsment for the physician for such coverage enough?

We either endorse a locum tenen on to an existing policy or issue a separate policy for the locum tenen depending on the individual situation. When the situation falls under the true definition of locum tenens, it is usual and customary to endorse a locum tenen on to the policy when a physician works in the place of the regular physician when the regular physician is absent. However, there are two situations where a separate policy makes more sense as follows: (1) Some physician practices bring in a locum tenens when they are not really replacing a physician and the locum tenen is really providing additional help to the practice on a temporary basis. In this situation, there is additional exposure and the practice can get coverage for the locum tenen with a separate policy. (2) Some locum tenens, even if they are working in the place of the regular physician when the regular physician is absent, prefer separate coverage because there is a potential gap in coverage if they are added to a policy by endorsement and they want to ensure seamless coverage. The potential gap in coverage arises in the event that the regular physicians claims made policy expires or is cancelled and tail is not purchased. In that event, the locum tenen physician has no coverage if a claim were to arise from when they filled in for the regular physician.

4. In regard to the retrospective rating plan, is the $1,000,000 premium for medical malpractice alone - not including general liability? In regard to the cancellation of the policy with the retrospective rating plan, the term "null and void" should be rephrased to indicate it will just no longer apply.

Yes. The $1,000,000 premium is for medical malpractice alone. MedMal Direct does not provide general liability coverage. We have revised page 15.1-U of the Underwriting Rates and Rules Manual - Illinois to rephrase the term null and void. Please see updates in the redlined and revised manual attached to this response.

5. Under Defense Costs, pursuant to 215 ILCS 5/143 (2), defense costs must be paid as supplement to the limits of liability.

We have revised page 16-U of the Underwriting Rates and Rules Manual - Illinois to comply with 215 ILCS 5/143 (2). Please see updates in the redlined and revised manual attached to this response.

6. Pursuant to Company Bulletin 2011-05, the schedule rating plan cannot exceed a credit or debit of 25%.

SERFF Tracking #:	*MERL-129004724*	***State Tracking #:***		***Company Tracking #:***	*MERL-129004724*

State:	*Illinois*	***Filing Company:***	*MedMal Direct Insurance Company*
TOI/Sub-TOI:	*11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons*		
Product Name:	*MMDIC IL Initial Rates Filing*		
Project Name/Number:	*/*		

We have revised page 20-U of the Underwriting Rates and Rules Manual - Illinois to comply with Company Bulletin 2011-05. Please see updates in the redlined and revised manual attached to this response.

7. Where are the rates? I only see discounts, factors, and aggregates.

The base rate, rating factors, and specialty classification listing are located on pages 29-U and 30-U.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Manual
Comments:	
Attachment(s):	MDIC-IL-RateManual (01-2014) v2 clean.pdf MDIC-IL-RateManual (01-2014) v2 redlined.pdf
Previous Version	
Satisfied - Item:	*Manual*
Comments:	
Attachment(s):	*MDIC-IL-RateManual (01-2014).pdf*

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Thank you for your review of this filing.

Sincerely,

Deb Hamilton

State: Illinois **Filing Company:** MedMal Direct Insurance Company
TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons
Product Name: MMDIC IL Initial Rates Filing
Project Name/Number: /

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	02/10/2014
Submitted Date	02/10/2014

Dear Gayle Neuman,

Introduction:

Thank you for your review of our filing

Response 1

Comments:

We have revised the effective date to be "On Approval". It is our understanding that MedMal Direct Insurance Company is now licensed. Please let us know if there are any issues.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,
Deb Hamilton

State: *Illinois* **Filing Company:** *MedMal Direct Insurance Company*
TOI/Sub-TOI: *11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons*
Product Name: *MMDIC IL Initial Rates Filing*
Project Name/Number: */*

Note To Reviewer

Created By:

Deb Hamilton on 05/12/2014 08:42 AM

Last Edited By:

Gayle Neuman

Submitted On:

05/12/2014 08:49 AM

Subject:

Effective Date

Comments:

The Company would like to keep the effective date of January 15, 2014.

Thank you.

State: *Illinois* **Filing Company:** *MedMal Direct Insurance Company*
TOI/Sub-TOI: *11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons*
Product Name: *MMDIC IL Initial Rates Filing*
Project Name/Number: */*

Note To Filer

Created By:

Gayle Neuman on 05/09/2014 09:18 AM

Last Edited By:

Gayle Neuman

Submitted On:

05/12/2014 08:49 AM

Subject:

effective date - 2nd request

Comments:

The Department of Insurance has now completed its review of this filing. You previously requested the filing be effective January 15, 2014. Was the filing put in effect on that date or do you wish to have a different effective date? Your prompt response is appreciated.

State: Illinois **Filing Company:** MedMal Direct Insurance Company
TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons
Product Name: MMDIC IL Initial Rates Filing
Project Name/Number: /

Note To Filer

Created By:

Gayle Neuman on 05/02/2014 08:35 AM

Last Edited By:

Gayle Neuman

Submitted On:

05/12/2014 08:49 AM

Subject:

effective date

Comments:

The Department of Insurance has now completed its review of this filing. You previously requested the filing be effective January 15, 2014. Was the filing put in effect on that date or do you wish to have a different effective date? Your prompt response is appreciated.

State: *Illinois* **Filing Company:** *MedMal Direct Insurance Company*
TOI/Sub-TOI: *11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons*
Product Name: *MMDIC IL Initial Rates Filing*
Project Name/Number: */*

Reviewer Note

Created By:

Caryn Carmean on 05/01/2014 03:58 PM

Last Edited By:

Gayle Neuman

Submitted On:

05/12/2014 08:49 AM

Subject:

Actuarial Review

Comments:

Actuarial Review completed,

State: *Illinois* **Filing Company:** *MedMal Direct Insurance Company*
TOI/Sub-TOI: *11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons*
Product Name: *MMDIC IL Initial Rates Filing*
Project Name/Number: */*

Post Submission Update Request Processed On 02/10/2014

Status:	Allowed
Created By:	Deb Hamilton
Processed By:	Gayle Neuman
Comments:	

General Information:

Field Name	Requested Change	Prior Value
Effective Date Requested (New)	On Approval	01/15/2014
Effective Date Requested (Renew)	On Approval	01/15/2014

SERFF Tracking #:	*MERL-129004724*	***State Tracking #:***		***Company Tracking #:***	*MERL-129004724*

State:	*Illinois*	***Filing Company:***	*MedMal Direct Insurance Company*
TOI/Sub-TOI:	*11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons*		
Product Name:	*MMDIC IL Initial Rates Filing*		
Project Name/Number:	*/*		

Rate Information

Rate data applies to filing.

Filing Method:	Use and File
Rate Change Type:	Neutral
Overall Percentage of Last Rate Revision:	%
Effective Date of Last Rate Revision:	
Filing Method of Last Filing:	

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	Number of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
MedMal Direct Insurance Company	%	%				%	%

SERFF Tracking #:	*MERL-129004724*	***State Tracking #:***		***Company Tracking #:***	*MERL-129004724*

State:	*Illinois*	***Filing Company:***	*MedMal Direct Insurance Company*
TOI/Sub-TOI:	*11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons*		
Product Name:	*MMDIC IL Initial Rates Filing*		
Project Name/Number:	*/*		

Supporting Document Schedules

Satisfied - Item:	Explanatory Memorandum
Comments:	
Attachment(s):	IL Explanatory Memorandum v2.pdf MDIC IL Base Rate Comparison.pdf IL - Rating Factor Comparisons.pdf
Item Status:	
Status Date:	

Bypassed - Item:	Form RF3 - (Summary Sheet)
Bypass Reason:	This is an initial filing.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Certification
Comments:	
Attachment(s):	Filing Certification - Completed.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Manual
Comments:	
Attachment(s):	MDIC-IL-RateManual (01-2014) v2 clean.pdf MDIC-IL-RateManual (01-2014) v2 redlined.pdf
Item Status:	
Status Date:	

Bypassed - Item:	Request to Maintain Data as Trade Secret Information
Bypass Reason:	N/A
Attachment(s):	
Item Status:	
Status Date:	

MedMal Direct Insurance Company
Illinois Medical Malpractice Program
Initial Rate and Rule Filing
Explanatory Memorandum

This is the initial filing of rates and rules for MedMal Direct Insurance Company (MMDIC) for their new Illinois Physicians & Surgeons Professional Liability Program. The proposed effective date is 1/15/2014. MMDIC intends to write new business in this program.

BASE RATE DEVELOPMENT

The basis for the rates proposed for this program is a comparison across several companies who write Medical Malpractice in Illinois. These companies include ISMIE Mutual Insurance Company (ISMIE), Medicus Insurance Company (Medicus), Doctors Direct Insurance, Inc. (DDI), The Medical Protective Company (MedPro), ProAssurance Casualty Company (ProAssurance), and The Doctors Company (TDC). Because companies vary in the amount of coverage applicable to an unadjusted base rate, we developed premiums by class by competitor for a generic base risk with the following characteristics:

- Limits of $1 million/$3 million
- Claims Made Mature
- Chicago area

We relied on the same specialty definitions that MMDIC uses in other states. We have mapped competitor premiums to the MMDIC classes based on the class descriptions within each competitor's manual.

We then grouped each of the premiums by class into MMDIC class code groupings. Based on the competitors' premium in these groupings, we reclassified several of the MMDIC classes into new class codes. Our intent in doing this was to increase homogeneity with class codes. We also analyzed MMDIC class code relativities from their Georgia and Texas programs and revised the relativities based on Illinois competitor premiums. This analysis can be seen in the "Base Rate Comparison" exhibit. As shown, base rates by specialty are close to the range of competitor rates.

As a direct writer, MMDIC's expense overhead is considerably lower than that of some of the competitors. The company's proposed rates reflect this difference.

RATING FACTOR DEVELOPMENT

The basis for the rating factors proposed is a comparison across several companies including ISMIE, DDI, TDC, Medicus, MedPro, and ProAssurance. Listed below are comments on how we arrived at the primary rating factors for the program:

Territories – We reviewed the territory structure and factors used by all competitors. Based on this review, the Company selected the proposed territories as shown on the associated exhibit. The factors were selected based on ISMIE territories and factors.

Increased Limit Factors – We reviewed the increased limit factors used by all competitors as well as the MMDIC Georgia and Texas programs. The factors were selected within the ranges of all companies.

Claims Made Maturity – We reviewed the claims made maturity factors used by all competitors as well as the MMDIC Georgia and Texas programs, and selected factors within the range of these companies.

Extended Reporting – We reviewed the extended reporting rules used by all competitors as well as the MMDIC Georgia and Texas programs, and selected factors within the range of these companies. The Company has also selected to keep the same loss ratio experience factors as in their Florida program.

Allied Healthcare – We reviewed the allied healthcare rules used by Medicus, TDC, ProAssurance, and ISMIE as well as the MMDIC Georgia and Texas programs, and selected factors within the range of these companies.

New Physician – We reviewed the new physician discounts used by all competitors as well as the MMDIC Georgia and Texas programs, and selected factors identical to the Medicus program and the current MMDIC Georgia and Texas programs.

Part Time Practice Rate – We reviewed the part time practice rate discounts used by all competitors as well as the MMDIC Georgia and Texas programs, and chose to keep the same rule as in the current MMDIC Georgia and Texas programs.

Sabbatical/Leave of Absence – We reviewed the sabbatical/leave of absence rules used by ISMIE, MedPro, DDI, as well as the MMDIC Georgia and Texas programs, and chose to keep the rule as in the current MMDIC Georgia and Texas programs.

Corporation Coverage – We reviewed the corporation coverage factors offered by ProAssurance and the MMDIC Georgia program, and selected factors identical to MMDIC Georgia program.

Deductibles – We reviewed the deductible credit factors used by Medicus, MedPro, ProAssurance, and DDI, as well as the MMDIC Georgia and Texas programs, and selected factors identical to ProAssurance.

Claims-Free – We reviewed the claims-free discounts offered by all competitors as well as the MMDIC Georgia and Texas programs, and selected factors identical to the Medicus programs.

Other rules and rating factors are the same as in MMDIC's Georgia program, and we consider them appropriate for use in Illinois. These include: Hospital Medical Staff Groups/Medical Groups, Retrospective Rating Plan, Vicarious Liability for Supervision of Nurse Midwives, Claim Surcharge Program, and Endorsed Carrier Discount Program, Expense Savings, Defense Expenses within Limits discount, Waiver of Consent to Settle discount, New to Company credit, and Risk Management discount.

CONCLUSION

We believe that this filing contains all information necessary to make a decision that the rates and rules are reasonable, comply with the laws of the state of Illinois, and that the rates are not excessive, inadequate or unfairly discriminatory.

Prepared By:

Meg Glenn, FCAS, MAAA
Merlinos & Associates, Inc.
3274-B Medlock Bridge Rd.
Peachtree Corners, GA 30092
678-684-4856
770-453-9776 fax
mglenn@merlinosinc.com

Chicago Rates - Mature, $1M/$3M 28,500

Med Mal Direct Specialty Description	Surgery Level	TX Class	TX Rel	GA Class	GA Rel	Prop IL Class	Prop IL Rel	Prop IL Rates	Average Rate	2012 ISMIE Mutual Rates	2007 Doctors Direct Rates	2013 Medicus Rates	2012 MedPro Rates	2013 TDC Rates	2010 ProAssurance Rates
Chiropractor	No Surgery	0A	0.365	0A	0.365	0A	0.365	$ 9,457	$ 4,585			$ 2,906		$ 6,264	
Allergy	Other	0D	0.7	0E	0.8	0B	0.56	$ 14,509	$ 17,571	$ 16,256	$ 16,500	$ 15,401	$ 19,516	$ 16,400	$ 21,355
Forensic Medicine	No Surgery	0D	0.7	0	0.9	0B	0.56	$ 14,509	$ 18,236	$ 16,256	$ 20,010	$ 15,401	$ 19,516	$ 16,879	$ 21,355
Nutrition	No Surgery	0D	0.7	0E	0.8	0B	0.56	$ 14,509	$ 17,232				$ 19,516	$ 14,947	
Podiatrist	No Surgery	0A	0.365	0A	0.365	0B	0.56	$ 14,509	$ 23,201	$ 21,720		$ 29,059		$ 20,671	$ 21,355
General Preventative Med – Aerospace Med	No Surgery	0	0.9	0	0.9	0C	0.65	$ 16,841	$ 19,003		$ 20,010	$ 20,632	$ 19,516	$ 15,854	
General Preventative Med – Occupational Med	No Surgery	0	0.9	0	0.9	0C	0.65	$ 16,841	$ 21,102	$ 16,256	$ 20,010	$ 20,632	$ 19,516	$ 19,087	$ 31,110
General Preventative Med – Public Health	No Surgery	0	0.9	0	0.9	0C	0.65	$ 16,841	$ 19,108	$ 16,256	$ 20,010	$ 20,632	$ 19,516	$ 16,879	$ 21,355
General Preventive Med – All Other	No Surgery	0D	0.7	0E	0.8	0C	0.65	$ 16,841	$ 19,473		$ 20,010	$ 20,632	$ 19,516	$ 15,854	$ 21,355
Otorhinolaryngology	No Surgery	1A	1.1	1A	1.1	0C	0.65	$ 16,841	$ 19,467	$ 16,256	$ 20,010	$ 15,401	$ 26,019	$ 17,758	$ 21,355
Physical Medicine & Rehab	No Surgery	0	0.9	0E	0.8	0C	0.65	$ 16,841	$ 20,107	$ 16,256	$ 16,500	$ 29,059		$ 17,363	$ 21,355
Physical Medicine & Rehab – Pain Management	Other	1B	1.15	1B	1.15	0C	0.65	$ 16,841	$ 22,024	$ 16,256	$ 16,500	$ 38,648		$ 17,363	$ 21,355
Dermatology – All Other	No Surgery	0D	0.7	0F	0.85	0D	0.7	$ 18,136	$ 20,395	$ 21,720	$ 20,010	$ 20,632	$ 19,516	$ 19,135	$ 21,355
Dermatopathology	No Surgery	0D	0.7	0F	0.85	0D	0.7	$ 18,136	$ 20,203	$ 21,720	$ 20,010	$ 20,632	$ 19,516	$ 19,135	
Endocrinology / Diabetes	No Surgery	1	1	1A	1.1	0E	0.8	$ 20,727	$ 24,784	$ 21,720	$ 30,000	$ 20,632	$ 26,019	$ 25,550	
Opthalmology	No Surgery	0	0.9	0	0.9	0E	0.8	$ 20,727	$ 21,984	$ 21,720	$ 20,010	$ 20,632	$ 19,516	$ 18,916	$ 31,110
Opthalmology	Other	0	0.9	0	0.9	0E	0.8	$ 20,727	$ 21,844	$ 21,720	$ 20,010	$ 29,059	$ 19,516	$ 18,916	
Pathology	No Surgery	0	0.9	1	1	0E	0.8	$ 20,727	$ 26,772	$ 21,720	$ 24,000	$ 20,632	$ 26,019	$ 27,396	$ 40,865
Pediatrics	No Surgery	1A	1.1	1A	1.1	0E	0.8	$ 20,727	$ 26,588	$ 21,720	$ 30,000	$ 20,632	$ 30,572	$ 25,493	$ 31,110
Psychiatry / Psychoanalysis	No Surgery	0	0.9	0	0.9	0E	0.8	$ 20,727	$ 25,290	$ 21,720	$ 24,000	$ 20,632	$ 26,019	$ 18,506	$ 40,865
Rheumatology	No Surgery	1	1	1A	1.1	0E	0.8	$ 20,727	$ 25,884	$ 23,540	$ 24,000	$ 20,632	$ 30,572	$ 25,452	$ 31,110
Broncho-Esophagology	Other	1	1	0	0.9	0	0.9	$ 23,318							
Dermatology – All Other	Minor Surgery	1	1	1	1	0	0.9	$ 23,318	$ 30,207	$ 21,720	$ 30,000	$ 29,059	$ 26,019	$ 33,579	$ 40,865
Dermatopathology	Minor Surgery	1	1	1	1	0	0.9	$ 23,318	$ 28,581	$ 21,720	$ 30,000	$ 29,059	$ 26,019	$ 33,579	$ 31,110
Geriatrics	No Surgery	1	1	0	0.9	0	0.9	$ 23,318	$ 25,973	$ 23,540	$ 24,000	$ 29,059	$ 26,019	$ 27,245	
Hypnosis	No Surgery	0	0.9	0	0.9	0	0.9	$ 23,318							
Not in Active Practice	No Surgery	0	0.9	0	0.9	0	0.9	$ 23,318							
Palliative / Hospice Care	No Surgery	0	0.9	0	0.9	0	0.9	$ 23,318							
Pathology	Minor Surgery	1A	1.1	1A	1.1	0	0.9	$ 23,318	$ 27,336	$ 21,720	$ 24,000	$ 20,632	$ 42,932	$ 27,396	
Sleep Medicine	Other	0	0.9	0	0.9	0	0.9	$ 23,318	$ 38,112	$ 38,112					
Maternal Fetal Medicine	Other	1	1	1	1	1	1	$ 25,909							
Not in Active Practice	Major Surgery	1	1	1	1	1	1	$ 25,909							
Nuclear Medicine	No Surgery	0	0.9	1	1	1	1	$ 25,909	$ 25,650	$ 32,648	$ 30,000	$ 20,632	$ 19,516	$ 25,454	
Pharmacology – Clinical	No Surgery	0	0.9	1	1	1	1	$ 25,909	$ 26,019				$ 26,019		
Physicians – NOC	No Surgery	1C	1.2	1	1	1	1	$ 25,909	$ 29,799			$ 20,632		$ 27,900	$ 40,865
Family/General Practice	**No Surgery**	**1A**	**1.1**	**1A**	**1.1**	**1A**	**1.1**	**$ 28,500**	**$ 32,411**	**$ 32,648**	**$ 30,000**	**$ 29,059**	**$ 30,572**	**$ 31,319**	**$ 40,865**
Hematology / Oncology / Neoplastic Disease	No Surgery	1A	1.1	1A	1.1	1A	1.1	$ 28,500	$ 33,241	$ 32,648	$ 30,000	$ 29,059	$ 36,426	$ 30,449	$ 40,865
Nephrology	No Surgery	0	0.9	1	1	1A	1.1	$ 28,500	$ 33,461	$ 36,288	$ 35,010	$ 29,059	$ 30,572	$ 28,970	$ 40,865
Opthalmology	Minor Surgery	1A	1.1	1E	1.3	1A	1.1	$ 28,500	$ 31,045	$ 32,648	$ 30,000	$ 29,059	$ 30,572	$ 23,126	$ 40,865
Cardiology / Cardiovascular Disease	No Surgery	1A	1.1	1C	1.2	1C	1.2	$ 31,091	$ 34,356	$ 36,288	$ 35,010	$ 29,059	$ 36,426	$ 28,489	$ 40,865
Endocrinology / Diabetes	Minor Surgery	1A	1.1	1C	1.2	1C	1.2	$ 31,091	$ 35,593	$ 32,648	$ 42,000	$ 31,965	$ 36,426	$ 34,924	
Geriatrics	Minor Surgery	1D	1.25	1C	1.2	1C	1.2	$ 31,091	$ 34,873	$ 23,540	$ 42,000	$ 38,648	$ 42,932	$ 27,245	
Gynecology	No Surgery	1	1	0	0.9	1C	1.2	$ 31,091	$ 33,067	$ 38,112	$ 35,010	$ 31,965	$ 26,019	$ 26,430	$ 40,865
Radiology – Therapeutic (Radiation Oncology)	Other	1E	1.3	1E	1.3	1C	1.2	$ 31,091	$ 42,769	$ 29,004	$ 42,000	$ 29,059	$ 57,242	$ 38,934	$ 60,376
Infectious Disease	No Surgery	1A	1.1	1A	1.1	1D	1.25	$ 32,386	$ 38,322	$ 36,288	$ 35,010	$ 31,965	$ 42,932	$ 45,413	
Internal Medicine	No Surgery	1	1.1	1C	1.2	1E	1.3	$ 33,682	$ 36,668	$ 38,112	$ 37,500	$ 35,161	$ 30,572	$ 37,797	$ 40,865
Anesthesiology	Other	1E	1.3	1G	1.5	1F	1.35	$ 34,977	$ 39,403	$ 39,932	$ 37,500	$ 35,161	$ 36,426	$ 36,777	$ 50,621
Hospitalist	Other	1E	1.3	1C	1.2	1F	1.35	$ 34,977	$ 39,489	$ 38,112	$ 35,010	$ 54,922	$ 33,305	$ 34,721	$ 40,865
Opthalmology	Major Surgery	1D	1.25	1G	1.5	1F	1.35	$ 34,977	$ 36,936	$ 32,648	$ 35,010	$ 29,059	$ 33,305	$ 40,973	$ 50,621
Podiatrist	Minor Surgery	1A	1.1	0	0.9	1F	1.35	$ 34,977	$ 37,764	$ 41,752	$ 46,500	$ 29,059		$ 40,399	$ 31,110
Radiology – Diagnostic	Other	1D	1.25	1C	1.2	1F	1.35	$ 34,977	$ 43,104	$ 41,752	$ 37,500	$ 35,161	$ 42,932	$ 40,900	$ 60,376

Urgent Care	No Surgery	1C	1.2	1C	1.2	1F	1.35	$ 34,977	$ 41,956			$ 46,500	$ 33,418	$ 36,426	$ 33,059	$ 60,376
Anesthesiology / Pain Management	Other	1E	1.3	1H	1.65	1G	1.5	$ 38,864	$ 44,522	$ 39,932		$ 37,500	$ 35,161	$ 36,426	$ 38,224	$ 79,887
Gastroenterology	No Surgery	1A	1.1	1E	1.3	1G	1.5	$ 38,864	$ 42,552	$ 47,216		$ 42,000	$ 33,418	$ 42,932	$ 39,122	$ 50,621
Hematology / Oncology / Neoplastic Disease	Minor Surgery	1D	1.25	1G	1.5	1G	1.5	$ 38,864	$ 42,818	$ 32,648		$ 35,010	$ 38,648	$ 50,738	$ 39,485	$ 60,376
Infectious Disease	Minor Surgery	1G	1.5	2	1.75	1G	1.5	$ 38,864	$ 43,373	$ 36,288		$ 42,000	$ 42,426	$ 50,738	$ 45,413	
Nephrology	Minor Surgery	1C	1.2	1C	1.2	1G	1.5	$ 38,864	$ 43,980	$ 41,752		$ 42,000	$ 35,161	$ 42,932	$ 41,656	$ 60,376
Neurology	No Surgery	1C	1.2	1H	1.65	1G	1.5	$ 38,864	$ 43,172	$ 47,216		$ 46,500	$ 31,965	$ 42,932	$ 39,800	$ 50,621
Podiatrist	Major Surgery	1G	1.5	1	1	1G	1.5	$ 38,864	$ 37,764	$ 41,752		$ 46,500	$ 29,059		$ 40,399	$ 31,110
Pulmonary Diseases	No Surgery	1A	1.1	1G	1.5	1G	1.5	$ 38,864	$ 43,018	$ 41,752		$ 42,000	$ 35,161	$ 50,738	$ 37,837	$ 50,621
Urgent Care	Minor Surgery	1G	1.5	2A	1.9	1G	1.5	$ 38,864	$ 37,659			$ 46,500	$ 33,418		$ 33,059	
Gastroenterology	Minor Surgery	1G	1.5	1G	1.5	1H	1.65	$ 42,750	$ 47,413	$ 47,216		$ 42,000	$ 42,426	$ 50,738	$ 41,721	$ 60,376
Gastroenterology	Major Surgery	2B	2	2C	2.25	1H	1.65	$ 42,750	$ 51,379	$ 47,216		$ 42,000		$ 64,922		
Otorhinolaryngology	Minor Surgery	1F	1.35	2	1.75	1H	1.65	$ 42,750	$ 46,313	$ 47,216		$ 42,000	$ 42,426	$ 42,932	$ 42,930	$ 60,376
Pediatrics	Minor Surgery	1D	1.25	1C	1.2	1H	1.65	$ 42,750	$ 46,062	$ 47,216		$ 46,500	$ 42,426	$ 42,932	$ 36,922	$ 60,376
Physicians – NOC	Minor Surgery	1G	1.5	1C	1.2	1H	1.65	$ 42,750	$ 48,051				$ 42,426		$ 41,351	$ 60,376
Cardiology / Cardiovascular Disease	Minor Surgery	1H	1.65	2A	1.9	2	1.75	$ 45,341	$ 53,318	$ 47,216		$ 55,500	$ 42,426	$ 50,738	$ 51,942	$ 72,083
Cardiovascular Disease – Interventional	Minor Surgery	1H	1.65	2A	1.9	2	1.75	$ 45,341	$ 53,318	$ 47,216		$ 55,500	$ 42,426	$ 50,738	$ 51,942	$ 72,083
Cardiovascular Disease – Invasive	Minor Surgery	1H	1.65	2A	1.9	2	1.75	$ 45,341	$ 54,618	$ 47,216		$ 55,500	$ 42,426	$ 50,738	$ 51,942	$ 79,887
Intensive Care Medicine	Other	1H	1.65	1H	1.65	2	1.75	$ 45,341	$ 54,121			$ 55,500		$ 64,922	$ 35,686	$ 60,376
Internal Medicine	Minor Surgery	1F	1.35	2A	1.9	2	1.75	$ 45,341	$ 48,746	$ 47,216		$ 46,500	$ 42,426	$ 50,738	$ 45,218	$ 60,376
Neurology	Minor Surgery	1F	1.35	2A	1.9	2	1.75	$ 45,341	$ 52,949	$ 47,216		$ 55,500	$ 42,426	$ 64,922	$ 47,253	$ 60,376
Family/General Practice	Minor Surgery	1H	1.65	2	1.75	2A	1.9	$ 49,227	$ 49,609	$ 50,860		$ 46,500	$ 46,204	$ 50,738	$ 42,976	$ 60,376
Urogynecology	Other	1A	1.1	2B	2	2A	1.9	$ 49,227								
Urological	Major Surgery	1H	1.65	2B	2	2A	1.9	$ 49,227	$ 52,916	$ 54,500		$ 49,500	$ 49,981	$ 50,738	$ 52,400	$ 60,376
Emergency Medicine	Minor Surgery	1F	1.35	2C	2.25	2B	2	$ 51,818	$ 69,678	$ 56,320		$ 72,000	$ 49,981	$ 78,735	$ 88,949	$ 72,083
Endocrinology / Diabetes	Major Surgery	2	1.75	3	2.75	2B	2	$ 51,818	$ 45,895	$ 32,648			$ 61,314		$ 43,724	
Gynecology	Minor Surgery	1D	1.25	1C	1.2	2B	2	$ 51,818	$ 52,547	$ 59,964		$ 55,500	$ 42,426	$ 42,932	$ 42,377	$ 72,083
Oral or Maxillofacial	Major Surgery	3	2.75	2D	2.5	2B	2	$ 51,818	$ 34,594	$ 32,648					$ 36,540	
Otorhinolaryngology	Major Surgery	2D	2.5	3B	3.25	2B	2	$ 51,818	$ 60,317	$ 63,604		$ 55,500	$ 49,981	$ 64,922	$ 55,810	$ 72,083
Radiology – Interventional	Other	1H	1.65	2A	1.9	2B	2	$ 51,818	$ 55,466	$ 59,964			$ 42,426	$ 57,242	$ 57,320	$ 60,376
Colon & Rectal	Major Surgery	2	1.75	3	2.75	2C	2.25	$ 58,295	$ 66,187	$ 59,964		$ 64,500	$ 54,922	$ 71,830	$ 66,021	$ 79,887
Geriatrics	Major Surgery	2D	2.5	3	2.75	2C	2.25	$ 58,295	$ 47,508	$ 23,540			$ 67,417	$ 71,830	$ 27,245	
Gynecology	Major Surgery	3	2.75	3A	3	2C	2.25	$ 58,295	$ 68,551	$ 63,604		$ 64,500	$ 61,314	$ 78,735	$ 71,067	$ 72,083
Hand Surgery	Major Surgery	3	2.75	3	2.75	2C	2.25	$ 58,295	$ 75,390	$ 63,604		$ 90,000	$ 61,314	$ 78,735	$ 59,286	$ 99,398
Head and Neck Surgery	Major Surgery	3	2.75	3C	3.5	2C	2.25	$ 58,295	$ 68,913	$ 63,604		$ 72,000	$ 61,314	$ 78,735		
Hematology / Oncology / Neoplastic Disease	Major Surgery	2C	2.25	3	2.75	2C	2.25	$ 58,295	$ 53,084	$ 32,648			$ 73,519			
Nephrology	Major Surgery	2D	2.5	3C	3.5	2C	2.25	$ 58,295	$ 42,089	$ 41,752			$ 42,426			
Family/General Practice	Major Surgery	3A	3	2D	2.5	2D	2.5	$ 64,773	$ 66,942	$ 70,892		$ 64,500	$ 61,314	$ 71,830	$ 61,031	$ 72,083
Oral or Maxillofacial (incl. Plastic)	Major Surgery	3	2.75	2D	2.5	2D	2.5	$ 64,773	$ 67,770			$ 99,000			$ 36,540	
Neonatology	Major Surgery	2C	2.25	2A	1.9	3	2.75	$ 71,250	$ 75,761	$ 96,384		$ 108,000	$ 61,314		$ 52,733	$ 60,376
Physician Doing Liposuction	Other	3	2.75	3	2.75	3	2.75	$ 71,250	$ 32,648	$ 32,648						
Plastic – ENT	Major Surgery	3A	3	2C	2.25	3A	3	$ 77,727	$ 94,705	$ 96,384		$ 99,000	$ 88,049	$ 78,735	$ 87,154	$ 118,909
Abdominal	Major Surgery	3A	3	5	4.75	3B	3.25	$ 84,205	$ 99,131			$ 90,000	$ 80,784	$ 127,083	$ 98,655	
General Surgery	Major Surgery	3A	3	4A	4	3B	3.25	$ 84,205	$ 102,166	$ 100,028		$ 90,000	$ 80,784	$ 127,083	$ 96,189	$ 118,909
Orthopedic Surgery (No Spine)	Major Surgery	3	2.75	3B	3.25	3B	3.25	$ 84,205	$ 97,479	$ 100,028		$ 99,000	$ 97,638	$ 78,735	$ 90,562	$ 118,909
Physicians – NOC	Major Surgery	4	3.75	3C	3.5	3B	3.25	$ 84,205	$ 88,049				$ 88,049			
Plastic Surgery	Major Surgery	3	2.75	3A	3	3B	3.25	$ 84,205	$ 94,705	$ 96,384		$ 99,000	$ 88,049	$ 78,735	$ 87,154	$ 118,909
Cardiology / Cardiovascular Disease	Major Surgery	4	3.75	5	4.75	4B	4.25	$ 110,114	$ 129,783	$ 129,164		$ 120,000		$ 107,742	$ 153,590	$ 138,419
Thoracic	Major Surgery	4	3.75	5	4.75	4B	4.25	$ 110,114	$ 124,468	$ 129,164		$ 120,000	$ 109,843	$ 107,742	$ 122,131	$ 157,930
Neuro-Otology	Major Surgery	5	4.75	4C	4.5	4C	4.5	$ 116,591								
Vascular	Major Surgery	4	3.75	4C	4.5	4C	4.5	$ 116,591	$ 125,228	$ 129,164		$ 120,000	$ 124,663	$ 107,742	$ 131,381	$ 138,419
OB and OB/Gyn	Major Surgery	4C	4.5	5C	5.5	5	4.75	$ 123,068	$ 138,171	$ 140,092		$ 132,000	$ 124,663	$ 127,083	$ 127,748	$ 177,441
Orthopedic Surgery (Incl. Spine)	Major Surgery	4B	4.25	4B	4.25	5	4.75	$ 123,068	$ 134,122	$ 151,016		$ 132,000	$ 134,253	$ 113,270	$ 116,260	$ 157,930
Traumatic	Major Surgery	4A	4	4C	4.5	5	4.75	$ 123,068	$ 137,254			$ 120,000	$ 124,663	$ 146,421		$ 157,930
Neurology	Major Surgery	7	6.75	8	8.5	7A	7.75	$ 200,795	$ 221,396	$ 231,144		$ 195,000	$ 205,738	$ 209,963	$ 231,044	$ 255,484

MedMal Direct Insurance Company
Illinois Rate Comparison

Territory Factors

	Medicus	ISMIE Mutual	ProAssurance	Doctors Direct	TDC	MedPro	**IL Selected**
Cook, St. Claire	1.00	1.000	1.00	1.000	1.00	1.00	1.00
Madison	1.00	1.050	1.00	1.000	1.00	1.00	1.00
Jackson	1.00	1.000	0.90	1.000	0.93	1.00	1.00
Will	1.00	1.000	1.00	1.000	0.93	1.00	1.00
Vermillion	0.90	0.900	0.90	0.900	0.93	0.90	0.90
Kane, McHenry	0.86	0.860	0.86	0.850	0.82	0.85	0.86
Lake	0.86	0.810	0.86	0.900	0.82	0.85	0.81
Winnebago	0.86	0.860	0.58	0.850	0.73	0.85	0.86
DuPage	0.76	0.710	0.86	0.750	0.73	0.70	0.71
Kankakee	0.76	0.810	0.71	0.750	0.73	0.75	0.81
Macon	0.76	0.710	0.71	0.750	0.62	0.70	0.71
Bureau, Coles, LaSalle, Ogle	0.72	0.710	0.71	0.700	0.73	0.70	0.71
Champaign	0.72	0.710	0.71	0.700	0.62	0.70	0.71
Dekalb, Randolph	0.72	0.710	0.71	0.700	0.73	0.70	0.71
Effingham	0.72	0.710	0.71	0.700	0.51	0.70	0.71
Grundy	0.62	0.670	0.58	0.600	0.51	0.60	0.67
Sangamon	0.62	0.570	0.71	0.600	0.62	0.55	0.57
Adam, Knox, Rock Island	0.48	0.470	0.58	0.525	0.47	0.45	0.47
Peoria	0.48	0.470	0.58	0.475	0.47	0.45	0.47
Washington, Williamson, Franklin, Hamilton, Bond, Clinton	0.53	0.520	0.71	0.525	0.51	0.50	0.52
Remainder	0.53	0.520	0.58	0.525	0.51	0.50	0.52

Proposed Territories:	
Cook, Jackson, St. Clair, Will	1.00
Vermilion	0.90
Kane, McHenry, Winnebago	0.86
Madison	1.00
Kanakee, Lake	0.81
Bureau, Champaign, Coles, DeKalb, DuPage, Effingham, LaSalle, Macon, Ogle, Randolph	0.71
Grundy	0.67
Adams, Knox, Peoria, Rock Island	0.47
Sangamom	0.57
Remaining	0.52

MedMal Direct Insurance Company
Illinois Rate Comparison

Increased Limit Factors

	MMDIC GA	MMDIC TX	Doctors Direct	MedPro 1A-2D	MedPro 3A-8	TDIC excl. chiro	TDIC chiro	Medicus Physicians	Medicus Surgeons	ProAssurance	ISMIE	**IL Selected**
100/300	0.500			0.386	0.364		0.526					0.500
100/400						0.482						
200/600	0.600	0.618		0.525	0.498		0.684					0.600
250/750	0.650		0.640				0.737			0.553		0.650
250/1000						0.668						
300/1200						0.704						
500/1000		0.790		0.776	0.753			0.719	0.719			
500/1500	0.810	0.805	0.780				0.842			0.780	0.727	0.727
500/2000						0.794						
1000/1000	0.950		0.970	0.961	0.956							0.950
1000/3000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
1000/4000				1.012	1.013							
2000/4000		1.300						1.360	1.550		1.358	
2000/5000	1.250					1.350	1.350					1.350
3000/5000		1.450						1.520	1.730			
3000/6000	1.396					1.554	1.554					1.554
4000/7000						1.673	1.673					
5000/8000						1.742	1.742					
6000/9000						1.798	1.798					
7000/10000						1.843	1.843					
8000/11000						1.884	1.884					
9000/12000						1.916	1.916					
10000/13000						1.946	1.946					
11000/14000						1.976	1.976					

MedMal Direct Insurance Company
Illinois Rate Comparison

Claims Made Maturity

Maturity	MMDIC GA	MMDIC TX	Medicus	TDC Incident	TDC Demand	MedPro	ISMIE	Doctors Direct	Proassurance
1	0.340	0.250	0.250	0.350	0.210	0.475	0.250	0.300	0.319
2	0.600	0.500	0.500	0.600	0.450	0.750	0.500	0.550	0.611
3	0.880	0.750	0.780	0.800	0.720	0.900	0.780	0.775	0.805
4	0.920	1.000	0.900	0.920	0.880	0.950	0.925	0.925	0.903
5	1.000		1.000	1.000	1.000	1.000	0.950	1.000	1.000
6							0.975		
7							1.000		

IL Selected
0.250
0.500
0.780
0.925
1.000

MedMal Direct Insurance Company
Illinois Rate Comparison

Extended Reporting

Maturity	MMDIC GA	MMDIC TX	Medicus	TDC Incident	TDC Demand	MedPro	ISMIE	Doctors Direct	ProAssurance
1	0.850	0.500	0.825	0.700	0.525	0.900	0.827	1.000	0.940
2	1.300	1.000	1.575	1.200	1.125	1.500	1.577	1.600	1.700
3	1.550	1.500	1.872	1.600	1.800	1.700	1.873	1.900	2.000
4	1.700	2.000	1.800	1.840	2.200	1.820	2.015	2.100	2.400
5	1.800			2.000	2.500	1.820	2.086		2.400
6							2.128		
7							2.180		

IL Selected
0.850
1.450
1.800
1.900
2.000

Applicable factors for each company converted to apply to mature claims made rates

Allied Healthcare

	MMDIC GA & TX	Medicus	TDC	ProAssurance	ISMIE Mutual	**IL Selected**
Nurse Practitioner	0.150	0.100	0.060	0.128	0.060	0.100
Physicians Assistant	0.150	0.100	0.060	0.080	0.060	0.100
Nurse Anesthetist	0.400	0.181	0.071	0.434	0.073	0.200
Nurse Midwife	0.750	1.384	0.734	1.520	0.858	1.000
Optometrist	0.100	0.050	0.034	0.056	0.027	0.050

***Rates compared to FP/GP No-Surgery Rates
Factors would be multiplied by 1.1 assuming that FP/GP remains at 1.1

New Physician Discount

Claims Year	MMDIC GA	MMDIC TX	MedPro	ProAssurance	Medicus	TDC	Doctors Direct	ISMIE Mutual	**IL Selected**
1	50%	30%	50%	50%	30%	50%	50%	50%	50%
2	30%	30%	30%	25%	30%	25%	30%	35%	30%
3	15%	20%	15%	0%	20%	0%	15%	20%	15%
3							0%	5%	

Part-Time Practice Rate Discount:

MMDIC GA & TX			**IL Selected**	
	Part - Time	Quarter Time	Part - Time	Quarter Time
New Policies w/no prior acts	50%	75%	50%	75%
First Year	15%	20%	15%	20%
Second Year	30%	40%	30%	40%
Third Year	50%	75%	50%	75%

Practice must be <1000 hours per year
Part-time practice is of long duration

ISMIE Mutual		MedPro		
		Hours/wk	Max. hrs/yr	Credit
Retired, Not in Practice	0.80	0-10	515	50%
Moonlighting (< 10 hrs/ wk)	0.73	11-20	1050	30%
Average Practice < 21 hrs/wk	0.40			

Doctors Direct	Medicus	ProAssurance		TDC	
Part - Time	Part - Time	Class	Discount		
50%	50%	1-7	50%	Part Time	50%
		8-15	35%	Quarter Time	75%

<20 hrs/week <20 hrs/week

Part Time- <20 hrs/week, or
<26 weeks/year

Quarter Time-<10 hrs/week
Practice for 3 years with
loss history of no more
than one claim with no severity

Sabbatical/Leave of Absence

MMDIC GA & TX	
Discount	50%
>45 days	

ISMIE Mutual	
Discount	25%
> 1 month	
< 1 year	

MedPro	
Discount	100%

Credit for period of time
of leave of absence
>45 days

Doctors Direct	
Discount	75%
45 to 180 days	

IL Selected	
Discount	50%
>45 days	

Corporation Coverage

MMDIC GA	
Group Size	1000/3000
1	0.200
2-4	0.150
5-9	0.120
10-19	0.090
20-49	0.070
50+	0.050
Vicarious Liab	

ProAssurance	
# Insureds	
2-5	15%
6-9	12%
10-19	9%
20-49	7%
50+	5%

IL Selected Separate Limits	
Group Size	1000/3000
1	0.200
2-4	0.150
5-9	0.120
10-19	0.090
20-49	0.070
50+	0.050
Vicarious Liab	

Deductibles

Indemnity Only

Deductible	MMDIC GA		MMDIC TX		Medicus	MedPro					ProAssurance	Doctors Direct	**IL Selected**
	1M/1M	1M/3M	.5M/1M	1M/3M		100,000	200,000	250,000	500,000	1,000,000	1M/3M	1M/3M	1M/3M
$ 5,000	1.6%	1.7%	3.2%	2.5%	2.5%						2.5%	1.5%	2.5%
$ 10,000	3.2%	3.5%	5.7%	4.5%	4.5%						4.5%	3.0%	4.5%
$ 15,000	4.8%	4.5%	7.6%	6.0%	6.0%						6.0%	5.0%	6.0%
$ 20,000	6.4%	6.0%	10.1%	8.0%	8.0%						8.0%	6.5%	8.0%
$ 25,000	8.0%	7.7%	11.4%	9.0%	9.0%						9.0%	7.5%	9.0%
$ 50,000	13.0%	12.0%	19.0%	15.0%	15.0%	7-28%	6-12%	5-20%	3-16%	2-14%	15.0%	12.0%	15.0%
$ 75,000												15.0%	20.5%
$ 100,000	21.0%	19.5%			25.0%	17-46%	15-26%	13-32%	10-25%	8-22%	25.0%	20.0%	25.0%
$ 150,000													32.0%
$ 200,000	33.5%	31.5%	47.5%	37.5%	37.5%		30-47%	26-52%	21-40%	17-33%	37.5%	30.0%	37.5%
$ 250,000	39.0%	36.5%	53.2%	42.0%	42.0%			32-60%	26-46%	21-38%	42.0%	35.0%	42.0%
$ 300,000												40.0%	
$ 500,000									43-69%	36-56%		45.0%	

Indemnity and ALAE

	MMDIC GA		MMDIC TX		Medicus	MedPro					ProAssurance	TDC	
	1M/1M	1M/3M	.5M/1M	1M/3M		100,000	200,000	250,000	500,000	1,000,000	1M/3M	1M/3M	1M/3M
$ 5,000	2.8%	2.6%	8.2%	6.5%	6.5%						6.5%	3.0%	6.5%
$ 10,000	5.5%	5.1%	14.6%	11.5%	11.5%						11.5%	5.0%	11.5%
$ 15,000	8.0%	7.5%	19.0%	15.0%	15.0%						15.0%		15.0%
$ 20,000	10.6%	9.9%	22.2%	17.5%	17.5%						17.5%		17.5%
$ 25,000	13.0%	12.0%	25.3%	20.0%	20.0%						20.0%	12%	20.0%
$ 50,000	21.0%	19.5%	38.6%	30.5%	30.5%	16-44%	14-24%	12-30%	9-24%	6-20%	30.5%	19%	30.5%
$ 75,000													36.0%
$ 100,000	29.5%	27.5%			40.0%	29-66%	26-41%	22-46%	17-35%	14-29%	44.5%	30%	40.0%
$ 150,000													47.0%
$ 200,000	43.0%	40.0%	69.7%	55.0%	55.0%		44-67%	39-70%	31-53%	25-43%	55.0%		55.0%
$ 250,000	48.5%	45.5%	73.5%	58.0%	58.0%			45-79%	36-60%	30-49%	58.0%		58.0%
$ 500,000									57-87%	46-70%			

Claims Free Discount

Years	MMDIC TX	Medicus	**IL Selected**
0	0.0%	0.0%	0.0%
1	2.0%	2.0%	2.0%
2	4.0%	4.0%	4.0%
3	6.0%	6.0%	6.0%
4	8.0%	8.0%	8.0%
5	10.0%	10.0%	10.0%
6	12.0%	12.0%	12.0%
7	14.0%	14.0%	14.0%
8	16.0%	16.0%	16.0%
9	18.0%	18.0%	18.0%
10+	20.0%	20.0%	20.0%

ALAE or indemnity payments >50% of base rates, minimum threshold $10,000

Doctors Direct		MedPro	
Years Claims Free		Years Claims Free	
< 3	0.0%	3-4	7.5%
3-4	5%	5-7	15%
5-7	10%	8-9	20%
8-9	15%	10+	25%
> 10	20		

TDC	If with company at least 3 years		
Reserves	Paid Indemnity	Paid ALAE	Discount
$0	$0	$0	25%
$0	$0	$1 to $20,000	20%
$1 to $50,000	$0	$0	20%
$0	$0	$20,001 to $50,000	15%
$0	$0	> $50,000	10%
$1 to $25,000	$0	$20,001 to $50,000	10%
$1 to $50,000	$0	$1 to $20,000	10%
$25,001 to $50,000	$0	$20,001 to $50,000	5%
$50,001 to $100,000	$0	$0 to $20,000	5%

If new to company:
No claims in most recent 5 years: 15%
Only 1 closed claim with no indemnity in most recent 5 years: 7.50%

ProAssurance			ISMIE Mutual	
Class	Period (yrs)	Discount	3	3.0%
1-4	10		4	6.0%
5-9	7	3% minimum requirements	5	8.0%
10-15	5	plus an additional 1% for	6	10.0%
		each claim free year	7	12.0%
		thereafter up to a max of	8	17.0%
		15%	9	18.0%
			10	19.0%
			11+	19.5%
If insured continuously for 10+ years, max increased to 20%			Insured for at least 3.5 years	

FILING CERTIFICATION

I hereby certify that the Company's rates are based on sound actuarial principles and are not inconsistent with the Company's Experience.

Actuary:

Meg H Glenn

Signature

Meg H. Glenn, FCAS, MAAA
Name (Please Print)

Officer of Company:

Signature

michael J. Wallace
Name (Please Print)
VP & CFO

SERFF Tracking Number: MERL-129004724

Company Filing Number: MERL-129004724

MedMal Direct Insurance Company
Underwriting Rates and Rules Manual - Illinois

General Rules

Binding Authority and Policy Effective Date

Coverage will not be bound until a properly completed application has been received and approved by the Company. Only the Company may bind coverage or issue Proof of Coverage.

The earliest effective date coverage can be bound will be the date the application is received by the Company. Under no circumstances will coverage be issued prior to the date the applicant was licensed to practice medicine.

The Company will make all determinations of acceptability of coverage.

Policy Period

The policy is typically issued for an annual term. Rates for periods shorter or longer than one (1) year are pro-rated from the annual rate. Exceptions to this rule may appear elsewhere in this manual.

Rates

Rates are determined using the Base Rate and Rating Factors section included in this manual and are a product of the Base Rate, class factor, territory factor, claims made factor and limit factor. Specialties are listed for each rate class in accordance with the Specialty Classification Listing section included in this manual.

If two or more classifications apply to the same physician, the classification with the higher rate will apply. Additionally, if the physician's practice is in two or more territories, the territory with the highest rate will apply. The Company will review such classification and territory designations for exceptions if they involve a minimal portion of the physician's practice. Each such case must be individually submitted for consideration.

The Specialty Classification Listing section included in this manual may not be all inclusive. In some cases, certain procedures deemed to be of higher risk may result in a different classification.

General Rules – continued

Premium Calculations

The premium is rounded to the nearest whole dollar and the premium applicable to each classification or miscellaneous charge is determined by the retroactive date and the policy effective date. The premium is determined by the number of years the retroactive date precedes the effective year.

If the retroactive month/day does not coincide with the policy effective date, the premium retroactive year is determined by the number of days between the two. If the retroactive month/day is 183 days (or less) before the effective month/day, use the effective month/day to determine the retroactive year premium to be used. If the retroactive month/day is 184 days (or more) before the effective month/day, use the prior year to determine the retroactive year premium.

Certain coverages may have an individual retroactive date. These are Corporation Coverage and Allied Healthcare Professional Coverage. Rates for these coverages are determined by their individual retroactive dates.

Premiums apply for each individual on the policy, and for each miscellaneous charge which might apply to that individual.

Endorsement changes will be rated in accordance with the rates in effect at the inception date of the policy or renewal being amended. “Tails” will be issued at the rates in effect at the time of cancellation of the policy.

Limit Changes

Changes in the limit of liability require a signed request by the physician. No change can be made until the request has been received by the Company, and will be effective on the date received unless a later date is specified.

All limit changes are retroactive as respects future claims from incidents which the insured was not aware might result in a claim, as of the effective date of the change. An acknowledgement of this will be sent to the insured to be signed and returned to use for every limit decrease.

Increased limits are subject to Company approval.

General Rules – continued

Cancellations

Unless a policy is cancelled as of inception or anniversary, the return premium will be computed on the basis of 90% pro rata of the unearned premium. Exceptions: cancellations at the request of the Company; cancellation of one member of a group with the policy remaining in force; cancellations due to the death of the insured; cancellation due to disability which qualifies for free tail; cancellation when fully retiring.

Prior notification will be provided for any cancellation by the Company. If the policy has been in force for 60 days or less, Thirty days prior notice for cancellation by the Company will be provided unless cancellation is for nonpayment of premium in which case Ten days prior notice will be provided. If the policy has been in force for over 60 days, Sixty days prior notice for cancellation by the Company will be provided unless cancellation is for nonpayment of premium in which case Ten days prior notice will be provided.

Any request for cancellation by the insured must be signed by the insured, and contain the effective date of cancellation as well as the policy number. Once a policy is issued, failure to pay the initial premium payment due will void a policy without a specific request for cancellation being made. Once a policy is issued and the initial premium payment has been received and accepted, the Company will provide a ten day advance notice of cancellation which will result in an earned premium charge for the coverage period.

Practice Outside of Illinois

Manual rates contemplate exposure as being derived from professional services rendered within the state. An exception will be allowed when a minimal portion of professional services are provided in another state, as approved by the Company.

Premium Payment Plan

When coverage is approved, the premium will be computed and a quotation forwarded. The policy will be bound and issued when the premium and any other required information has been received by the Company.

Premiums may be paid on an annual basis, or (subject to Company approval) under a Premium Payment Plan.

The Premium Payment Plan offers three options:

OPTION #1 - based on two semiannual payments. The first payment due will be 60% of this total, with the one subsequent payments in the amount of 40% of this total.

OPTION #2 - based on four quarterly payments. The first payment due will be 30% of this total, with the three subsequent payments in the amount of 23.33% of this total.

OPTION #3 - based on ten monthly payments. The first payment due will be 20% of this total, with the nine subsequent payments in the amount of 8.89% of this total.

Other payment plans are also available if requested by the insured. The terms of these other plans will be mutually agreed upon by the parties.

If there are endorsement charges during the policy year, any remaining installments will be adjusted for the amount of the charge, and a new schedule will be issued.

Extended Reporting Period Coverage (Tail)

The availability of "Tail" shall be governed by the terms and conditions of the policy and the following rules contained herein.

A policy canceled at any date after the original inception date is eligible for this coverage. An option to purchase "Tail" coverage will be provided by the Company, as part of the cancellation processing. Thirty days will be provided in the option period; after this period has expired, the coverage will no longer be available.

"Tail" processing is handled by the Company, based on the current filed rates in effect at the time of cancellation. The ERE factor shown below is applied to the mature claims made rate. Physicians between maturity years will be pro-rated.

Maturity	ERE Factor
1	0.850
2	1.450
3	1.800
4	1.900
Mature	2.000

When purchased, "Tail" coverage will be subject to an experience rating plan based on the claim experience of the prior active coverage as of the effective date of cancellation. The total payments and reserves for indemnity and loss adjustment expenses at the time of cancellation will be divided by the total liability premium paid to the company while insured, to determine the experience factor to be applied to the tail charge.

Loss Ratio	Experience Factor
Less than 100%	1.000
100% to 125%	1.100
125% to 150%	1.200
150% to 175%	1.300
175% to 200%	1.400
More than 200%	1.500

Exception: "Tail" coverage will be provided at no additional charge to any insured:

1. upon termination of coverage under this policy by reason of death,
2. upon termination of coverage under this policy by reason of total and permanent disability from the practice of medicine, or
3. upon termination of coverage under this policy by reason of permanent and complete retirement from the practice of medicine after being continuously insured under a medical professional liability policy for at least five years immediately preceding retirement and being continuously insured by the Company for at least one year immediately preceding retirement.

Only the following discounts will apply to the calculation of ERE premiums: Loss Free, Part-Time Practice Discount; New Physician Discount; Optional Coverage Discounts; Sabbatical/Leave of Absence; Deductible. All surcharges will apply to the calculation of ERE premiums.

Locum Tenens Coverage

If temporary coverage is required for a physician providing substitute coverage for an insured, a locum tenens policy may be issued or limited coverage may be added to the insured's policy by endorsement.

A potential locum tenens must submit an application for underwriting review and be licensed to practice medicine in the same state as the insured physician. The locum tenens must be employed by and providing temporary coverage for one of our insureds.

Upon approval, an option will be offered to issue on the following:

1. Endorse the insured's policy to cover ONLY professional services rendered on behalf of our insured physician for the time period specified. There will be a shared limit of liability, and no premium charge will apply. No individual "tail" coverage is available.

   This endorsement is limited ONLY to situations where a locum tenens is replacing an insured who will not be otherwise practicing during the coverage period. A signed option form must be on file for this option.

2. An individual policy will be issued for the employee, and then canceled on a pro-rata basis. Lump-sum "tail" coverage will be issued on a pro-rata basis for the coverage term. The policy and "tail" coverage must be paid in full. Under this option, the "tail" coverage is not optional.

Coverage under this rule will not be in effect for more than 180 consecutive days.

Premium Adjustment for Class or Territory Change

When an individual changes to a different classification or territory, there is a continuing exposure to claims from the prior class or territory. In order to provide for this continuing exposure, one of two rating methods shall be used. The methodology used will be determined at the discretion of the insured.

1. The rates of the two classifications or territories will be blended together using the number of days in the coverage period as the weight for each classification or territory. All credits and/or surcharges that would have applied if the change had not been made will continue to apply. If an extended reporting period (tail) is elected, the appropriate ERE Factor will be applied to the prior and current classification and then blended to determine the “tail” premium. All other rules for extended reporting period (tail) coverage apply.

2. A form of “tail” charge shall be applied.

   The charge will be based on the difference between the “tail” charge for the old classification and the new classification. It will be computed utilizing the “tail” rates and procedures in effect on the effective date of the policy or renewal being changed.

   The original retroactive date will be maintained for the new classification and/or territory. If the policy subsequently canceled, any “tail” premium applicable will be based only on the new classification and/or territory plus any remaining premium due for the change adjustment.

   If an insured becomes eligible under the terms of the policy for free “tail” coverage, any remaining charge for the change adjustment will also be considered within the terms of the free “tail” coverage.

   An insured who is already eligible for free “tail” coverage upon full retirement, may reduce to a lower classification without a premium adjustment.

Coverage Form

All coverages are written on a claims-made basis. All new policies will be issued with a retroactive date equal to the coverage effective date, unless the applicant is approved for Prior Acts Coverage. This coverage is provided by the use of a retroactive date prior to the new coverage effective date and is subject to specific approval by the Company.

Allied Healthcare Professional Coverage

Allied Healthcare Professional Coverage is available for certified Physician's Assistants, Nurse Anesthetists, Nurse Practitioners, and Nurse Midwives who are employed by our insured. The Allied Healthcare Professional will be specifically named on the policy and coverage may apply on a shared limit, separate limit or vicarious basis.

This coverage is required for employed certified Physician's Assistants, Nurse Anesthetists, Nurse Practitioners, and Nurse Midwives; or they must provide proof of individual coverage which specifies limits of liability greater than or equal to the same limits carried by the employer. If they are not listed on the Company's Coverage Summary as named insureds and do not have approved coverage elsewhere, the insured is not covered for any liability for the actions of such an employee.

Applications are required for each Allied Healthcare Professional and should be provided to the Company before the employee begins working for the insured. As is the case with physician applicants, each application is subject to prior approval by the Company before the coverage may be added. Coverage cannot be effective prior to receipt of notification.

The rates applicable to Allied Healthcare Professionals, along with the definitions of the rate categories are included in the Base Rate and Rating Factors section included in this manual.

A charge will apply for the employers' vicarious liability for each employee of the insured who does not have coverage on an individual MDIC policy. Charges for the vicarious liability are based on the allied healthcare professional's specialty and will be rated as 10% of the premium applicable if the allied healthcare professional had been insured with the Company with a separate limit of liability.

CompliancePro tector Coverage

CompliancePro tector Coverage is included as part of the medical professional liability premium and pays defense costs for covered proceedings (as defined in policy form) instituted by a regulatory or administrative body arising out of an insureds professional practice.

Limit per Physician: $50,000 per covered proceeding / $100,000 annual aggregate

Deductible: $1,000 per covered proceeding

Group Aggregate: A Group Aggregate Limit for Medicare/Medicaid also applies to groups and is determined based on the size of the group per the following table:

Group Size	Group Annual Aggregate
2 - 4	$100,000
5 – 9	$150,000
10 – 19	$200,000
20+	$250,000

CyberProtector Coverage

CyberProtector Coverage is included as part of the medical professional liability premium and pays for network related exposures arising out of an insureds professional practice.

Limit per Physician:

Multimedia Liability	$50,000 per claim
Security and Privacy Liability	$50,000 per claim
Privacy Regulatory Defense and Penalties	$50,000 per claim
Privacy Breach Response Costs, Patient Notification Expenses, and Patient Support and Credit Monitoring Costs	$50,000 per claim
Network Asset Protection	$50,000 per claim
Cyber Extortion	$50,000 per claim
Cyber Terrorism	$50,000 per claim

Aggregate per Physician: $50,000 annual aggregate

Group Aggregate: A Group Aggregate Limit for and is determined based on the size of the group per the following table:

Group Size	Group Annual Aggregate
1	$50,000
2 – 9	$100,000
10 – 24	$150,000
25+	$250,000

New Physician Discount

A new physician is a physician who is:

1. entering the first year of private practice following:

    a. completion of residency or a fellowship program in their specialty; or

    b. periods of obligatory payback in a military, university or government setting.

    A physician qualifying as a new physician may have up to one (1) year of employment after the completion of residency before being disqualified. We will not issue any prior acts coverage for this employment period.

2. an experienced physician who completes a residency or fellowship program in a different specialty and re-enters private practice in that different specialty.

Applicable Discounts

1. A 50% discount applies to first year claims made rates. This discount replaces any other applicable discount, except Deductibles. This discount may not be used if prior acts coverage applies.

2. A 30% discount applies to second year claims made rates.

3. A 15% discount applies to third year claims made rates.

Thereafter, standard rates apply. Loss Free Discounts may not be applied if a physician is receiving a New Physician Discount. Other discounts or surcharges may be applied in the second and third years of coverage.

Part-Time Practice Rate Discount

A physician will receive a part-time rate only if:

1. Practice does not exceed 1,000 hours per year for Part-Time, or 500 hours per year for Quarter-Time. The approximate practice time must be determined and will include the time the physician spends in patient care (including hospital rounds, completion of medical records, and consultations)

2. The part time practice is permanent, or of a long-term duration of at least one year, except for pregnancy. Maternity leave will be for at least three months and not to exceed twelve months.

Annual verification of eligibility is required, along with any special documentation which the Company may deem necessary. Policies issued under this rule will be written with the following discount applied to the annual premium otherwise applicable:

New policies with no prior acts coverage: 50% discount for Part-Time
75% discount for Quarter-Time

New policies with Prior acts coverage:

1. If the part-time start date is the same as the retroactive date, 50% discount for Part-Time or 75% discount for Quarter-Time.
2. If the part-time start date is after the retroactive date, the applicable discount will follow the schedule listed below for current insureds.

Current Insureds:

When a current insured becomes eligible for a part-time rate mid-term, the existing policy will be endorsed to reflect the appropriate discount.

Rates will be phased in over a period of time to reflect a premium adjustment for continued exposure of the prior acts practice activity. If the insured has been with the Company long enough to qualify for free tail if retired, the 50% discount for Part-Time or 75% discount for Quarter-Time discount will apply.

The discount applicable will be determined by the number of years at the part time activity per the following table:

	Part-Time	Quarter-Time
First year	15%	20%
Second year	30%	40%
Third Year	50%	75%

Sabbatical/Leave of Absence

A physician is provided premium relief when taking a leave of absence (including pregnancy, disability or continuing education) or a sabbatical when it exceeds 45 days. It cannot be used for vacation time.

To determine eligibility, the Company requires a signed statement from the insured stating the reason for the leave, the starting date and the anticipated ending date.

Discount for eligible physicians: 50% for all classes.

If the physician is receiving a New Physicians discount of 15% or 30%, that discount will be removed and replaced with the 50% discount above.

If a New Physician discount of 50% is being applied, the 50% discount will not apply.

If the physician is in his/her 1st or 2nd year of Part-Time practice (receiving 15% or 30% discount, respectively), the Part-Time discount will be removed and replaced with the 50% discount above. If the physician is in his/her 3rd or more year of Part-Time practice (receiving a 50% discount), the Part-Time discount will be removed and replaced with the 50% discount above. A Loss Free discount, if applicable, will still apply.

If the physician is in his/her 1st or 2nd year of Quarter-Time practice (receiving 20% or 40% discount, respectively), the Quarter-Time discount will be removed and replaced with the 50% discount above. If the physician is in his/her 3rd or more year of Quarter-Time practice (receiving a 75% discount), the Quarter-Time discount will be reduced to 25% and the 50% discount above will be added for a total discount of 75%. A Loss Free discount, if applicable, will still apply.

The classification and discounts will be returned to their original status upon notification of return to practice. No premium adjustment will be charged for this period of time.

Military Deployment

The Company will provide a temporary suspension of premiums during the period of deployment for physicians who are called to active duty. Eligible physicians must submit copies of their orders at the onset of the deployment and upon return to practice. Calculation of premium credit will be determined by the actual number of days deployed.

Corporation Coverage

Optional coverage with a separate limit of liability for a professional association, corporation or partnership is available.

If all physicians members' (shareholders or partners) are not insured by the Company, they may be added to the corporate coverage schedule, subject to underwriting approval, upon proof of acceptable individual coverage at the same limit (or higher) as the corporate limit. Otherwise, there is no corporate coverage for their actions. Charges for the vicarious liability are based on the physicians' specialty and will be rated as 10% of the premium applicable if the physician had been insured with the Company.

Ancillary personnel are covered under the corporate coverage as long as they are acting within the scope of their employment, even if working with an individual physician not included in the physician schedule.

Employed physicians insured elsewhere may be added to the schedule of physicians included in the corporate coverage with appropriate proof of other insurance (as is currently required). In this case, the usual vicarious liability charge will not apply; they will be rated as if they were insured physicians.

Charges for Allied Healthcare Professionals and other vicarious liability charges will be added to the corporate coverage on the same basis as is currently required.

Retroactive coverage for the corporate coverage can be considered. If approved; the same affidavit used for individual coverage will be used for the corporate coverage. The affidavit must be signed by the President or other authorized officer of the organization applying for the coverage. If all members (including employed physicians) do not have the same limit of liability individually, the limit available for the organization is the lowest limit of any individual physician scheduled.

RATES:

Coverage is calculated as a percentage of the physician premium. If the physician rate is discounted or surcharged, the final rate will be used to determine the charge.

Group Size	
1 physician	20.0%
2 - 4 physicians	15.0%
5 – 9 physicians	12.0%
10 – 19 physicians	9.0%
20 – 49 physicians	7.0%
50+ physicians	5.0%

If the retroactive date of the optional corporate coverage is later than the physician retroactive date, the physician rate for corporate coverage will be recomputed based on the corporate retroactive date for purposes of determining the corporate charge. If the scheduled physician is not insured with the Company, the corporate charge is based on the charge which would apply if insured by us.

Retrospective Rating Plan

Eligibility

The retrospective rating plan period is the one-year period beginning with the effective date of the Policy that is the subject of the Retrospective Premium Endorsement.

This rating plan is available to those insureds whose Standard Premium exceeds $1,000,000 per year. The rating elements will be defined in the Retrospective Rating Endorsement and on the remainder of this page.

Retrospective Premium Formula. The retrospective premium will be the sum of the Basic Premium plus the Excess Premium plus the product of the Incurred Losses times the Loss Conversion Factor, times the Tax Multiplier, subject to the Maximum and Minimum premium as described herein. Therefore, the retrospective premium shall be calculated by the following formula:

$$[BP + EP + (IL \times LCF)] \times TM$$

BP = Basic Premium = Basic Premium Factor x Standard Premium
EP = Excess Premium = Excess Premium Factor x Standard Premium
LCF = Loss Conversion Factor
IL = Incurred Losses
TM = Tax Multiplier

Retrospective Rating Plan Factors	
Policy Limit	Factor
Basic premium factor	0.264
Excess premium factor	0.200
Loss conversion factor	1.000
Tax multiplier	1.026
Minimum premium factor	0.476
Maximum premium factor	1.250

The Standard Premium is the total premium collected by the Company during the Plan year and is the premium that we would charge during the Plan year for the insurance subject to the retrospective rating if the retrospective premium rating had not been chosen (manual premium minus applicable discounts and/or credits).

Incurred losses means (1) all paid losses; plus (2) reserved losses as determined by us; (3) allocated loss adjustment expenses paid including but not limited to expenses associated with premiums on bonds, attorney fees, expert witness fees, court costs and interest payable in accordance with the provisions of the policy; plus (4) allocated loss adjustment expenses reserved as determined by us; plus (5) expenses incurred in seeking recovery against a third party.

Maximum and Minimum Premium. The Retrospective Premium will not be less than the Minimum Premium or more than the Maximum Premium.

Retrospective Rating Plan (continued)

First and Subsequent Retrospective Premium Adjustments. We will calculate the retrospective premium using all Incurred Losses we have as of (180) one hundred and eighty days after the rating plan period ends and, if necessary, annually thereafter. With respect to the loss limitation element, for each claim that remains open, it shall be assumed that the actual loss will equal the maximum possible loss limit for that claim for the purposes of calculating the retrospective premium adjustment. If the above calculation results in a premium that is less than amounts previously billed, then we will promptly pay any return premium adjustments that are due. If the above calculation results in a premium that is greater than amounts previously billed, then you shall make payment to us within (30) days.

Final Retrospective Premium Adjustment. The retrospective premium will be adjusted annually as described above until: (1) all claims have been closed; or (2) the paid losses and paid allocated loss adjustment expense used in the retrospective premium calculation causes the retrospective premium to equal the Maximum Premium. Notwithstanding any final calculation, we reserve the right to adjust the retroactive premium in the event that a closed claim is subsequently subject to Incurred Losses. In such event, you shall make payment to us within (30) thirty days for any such Incurred Losses subject to the loss limitation provision set forth in the Retrospective Premium Endorsement.

Paid Extended Reporting Period Endorsements. Paid extended reporting period endorsements shall not be eligible for retrospective rating and shall not be construed as being part of the Retrospective Premium Endorsement.

Special Valuation. We may make a special valuation based on the Retrospective Premium Formula contained herein as of any date that you are declared bankrupt or insolvent, make an assignment for the benefit of creditors, or are involved in reorganization, receivership, or liquidation.

Recovery From Others. We have your rights to recover all advances and payments, including those within the loss limitation amount, from anyone liable for the Incurred Losses. You will do everything necessary to protect those rights for us and to help us enforce them. If we recover any payment made under the Retrospective Premium Endorsement from anyone liable for Incurred Losses the amount we recover (after deducting from such recovery the expenses incurred in effecting such recovery paid by us) will first be applied to any payments made by us in excess of the loss limitation payments made by you. The remainder of the recovery, if any, will be credited against the amounts paid or reimbursed to you in accordance with the retrospective premium calculation.

Cancellation of Policy. If the Policy that is the subject of the Retrospective Premium Endorsement is cancelled, the effective date of cancellation will become the end of the retrospective rating period. If we cancel for nonpayment of premium, the Standard Premium shall become the applicable premium for the Policy notwithstanding the Retrospective Premium Endorsement, which shall no longer apply, and a pro rata refund of the unearned premium, less a ten percent (10%) cancellation charge, shall be returned. If you cancel, the Standard Premium for the rating period will be calculated according to the short rate cancellation procedure under the Policy. This premium will be the Minimum Premium and will be used to determine the Basic Premium. This Minimum Premium will also be used to determine the Excess Premium. The Maximum Premium will be based on the Standard Premium for the rating plan period, increased pro rata to 365 days.

Optional Coverage Discounts

A policyholder may elect to have the policy endorsed for any or all of the following and will receive the applicable discount:

Punitive Damage Exclusion – A 5% discount will apply when a policy is endorsed to exclude punitive damages coverage.

Waiver of Consent to Settle – A 5% discount will apply when a policy is endorsed to waive the right to consent to settle a claim and give the Company the sole right to investigate, negotiate and settle.

These discounts will be applied to the individual physicians or surgeons liability premiums.

Hospital Medical Staff Groups/Medical Groups

A Hospital Medical Staff Group is eligible for the premium discounts shown below. Coverage will be provided by issuing a policy which provides individual limits for each physician. Physicians currently insured will be eligible to enter a group program at their individual anniversary date. Each group may elect to have a common renewal date or allow the members to maintain their anniversary dates. If a common anniversary date is elected and the physician is entering at a date other than the Group effective date, new business and converting business will be issued a short term policy to expire on the anniversary date of the group. The rates in effect at the time of the effective date of the group shall apply to all individuals entering during that one-year period.

Group Discount	5%

This discount may not be combined with any Endorsed Carrier Discount or Expense Savings Discount plan.

“Refer to Company” Rating Rule

If an individual risk, before the application of any filed credits/debits, develops an annual premium of at least $100,000 at $1,000,000/$3,000,000 limits and such individual risk presents exposures or hazards different from those contemplated in the rates, rules and coverages filed on behalf of the Company, the otherwise applicable rates, rules and coverages may be modified accordingly. However, The Company shall maintain compliance with all Illinois laws and rules for any risk rated under this rule including maintaining all supporting documentation and completing all reporting in accordance with applicable state statutes and regulations.

Claim Surcharge Program

The premium applicable to those physicians who have experienced more than two "chargeable" claims over a period of five (5) years may be surcharged in accordance with the following table:

2 chargeable claims	50% surcharge
3 chargeable claims	150% surcharge
4 or more chargeable claims	500% surcharge

"Chargeable Claim" as it applies to this rule is defined as: any indemnity payment over $50,000 or any indemnity reserve of $100,000 or more. Each and every claim shall have a determination of whether or not it is "chargeable".

Schedule Rating Program

The Company has determined that significant variability exists in the hazards faced by physicians engaged in the practice of medicine.

Exposure conditions vary with respect to:

Exposure Condition	Credit	Debit
Qualifications/Training/Continuing Education, Experience, including: • Board Eligibility or Board Certification • Hospital Affiliations or Staff Privileges • Experience in Specialty • Accreditation • Cumulative years of patient experience	20%	20%
Practice Structure/Patterns (including, but not limited to: practice profile; practice stability; practice size; patient load; support staff; managed care network participation)	20%	20%
Risk Management (including, but not limited to: use of software; acceptance of specialty practice guides; employment of qualified risk manager, record-keeping practices; credentialing; quality assurance programs; peer review)	20%	20%
Employee selection, supervision, training and experience	5%	5%
Compliance with applicable regulations (OSHA, CLIA, etc.)	5%	5%
Cooperation with Underwriting/Claims/Defense Counsel	5%	5%

In recognition of these factors, the Company will apply a debit or credit to the otherwise applicable rate based upon the underwriter's overall evaluation of the risk.

The maximum credit will be 25%
The maximum debit will be 25%

Slot Rating

Coverage for a multi-physician group is available on a Slot Rating basis. Under this method, positions are covered rather than specific individuals and coverage will be provided on a shared limit basis. Since the Slot is continuous, individuals who depart the Slot will be able to report claims that occurred while they were part of the Slot. In the event a Slot is eliminated, an Extended Reporting endorsement for that Slot may be purchased for the Slot based on the applicable retroactive date, classification, territory, and limits. Individuals who depart the Slot may purchase, within 30 days of their departure, individual Extended Reporting Period Coverage based on the classification and territory of the Slot and based on the individual's Beginning Date, instead of Retroactive Date, and Departure Date, instead of cancellation date. The applicable manual slot rate will be determined by the classification of the Slot and will be allocated based upon the most appropriate of the following methods:

1. Full Time Equivalency – The Full Time Equivalency (FTE) is based on the total number of hours of medical practice per year that the Slot will be covering. The definition of one FTE is 2,500 hours per year. The minimum FTE assigned to any Slot is no less than 1.0.

2. Patient Visit Equivalency – The Patient Visit Equivalency (PVE) is based on the number of patient visits per year to be covered by the Slot. The number of patient visits equivalent to a physician year is based on the following:

Emergency Medicine:	5,400 visits per year
Urgent Care:	7,500 visits per year
Outpatient Clinic:	10,000 visits per year

For specialties not listed above, the number of patient visits equivalent to a physician year is 2,500 hours times the applicable rate of visits per hour. The rate of visits per hour is derived from the group's historical experience, subject to a minimum rate of 1 visit per hour and a maximum rate of 3 visits per hour. The minimum PVE assigned to any Slot is no less than 1.0.

The Slot's Annual Aggregate limit is determined based on the number of FTE or PVE:

FTE/PVE	Annual Aggregate
1	3 x the per incident limit
2	5 x the per incident limit
3	7 x the per incident limit
4 or more	9 x the per incident limit

The FTE's and annual visits reported to the Company for rating purposes are subject to audit, at the Company's discretion. Discounts for new physicians, part time or loss free cannot be used in conjunction with this rating rule.

Vicarious Liability for Supervision of Nurse Midwives (not employed by the insured)

For an additional charge of 5% of the premium for each nurse midwife supervised the Company will provide coverage within your existing limits of liability to cover the vicarious exposure.

Additionally, each nurse midwife must furnish evidence of insurance which specifies limits of liability greater than or equal to the same limits carried by the supervising physician.

Deductibles

Deductibles may apply to either damages (indemnity) or to damages and defense (indemnity and ALAE). The Deductibles listed below have no annual aggregate. If an annual aggregate is desired, the risk should be submitted for rating.

The Company will advance any deductibles due to the plaintiff. We will require reimbursement from the named insured within 30 days of notification that such amounts have been paid. The Company's liability to pay damages under the policy will be reduced by any applicable deductible(s).

	Credit for Indemnity Only	**Credit for Indemnity & ALAE**
	Policy Limits	Policy Limits
Deductible	1M / 3M	1M / 3M
$5,000	2.5%	6.5%
$10,000	4.5%	11.5%
$15,000	6.0%	15.0%
$20,000	8.0%	17.5%
$25,000	9.0%	20.0%
$50,000	15.0%	30.5%
$75,000	20.5%	36.0%
$100,000	25.0%	40.0%
$150,000	32.0%	47.0%
$200,000	37.5%	55.0%
$250,000	42.0%	58.0%

The above rate reduction factors apply to the respective policy limit rates in order to determine the appropriate deductible rate reduction. Factors for limits not shown on this table shall be determined by linear interpolation.

Loss Free Discount Program

Any physician, who is loss free as of the original effective date of new coverage, or the renewal date of current coverage, will qualify for the following discounts:

Loss Free Years	Discount
0	None
1	2.0%
2	4.0%
3	6.0%
4	8.0%
5	10.0%
6	12.0%
7	14.0%
8	16.0%
9	18.0%
10 or more	20.0%

Loss free status will be determined on Illinois experience only and will start as of the year Illinois practice commenced. The number of loss free years is calculated from the latter of: (1) January 1 of the year Illinois practice began or (2) the payment date of the last qualifying loss, to the physician's renewal date.

Exception: If a physician is relocating to Illinois from another state and can provide proof of continuous insurance coverage as well as a certified claim history, then the qualified loss free years will be accepted.

"Loss" as it applies to this rule is defined as: Any indemnity payment over $50,000, or any indemnity reserve of $100,000 or more. The number of loss free years is 0 if there is an indemnity reserve of $100,000 or more.

If loss free status changes between the time the renewal is issued and the actual effective date, the renewal will be reissued at the correct premium charge and the difference billed to the insured.

If a loss occurs during the year, the loss free status reverts to 0 years. However, the loss free credit will only change at renewal. In the event a reserve of $100,000 or more is subsequently settled for less than amount in definition, an endorsement will be issued to reflect all credits which were lost due to the reserve amount (if the credit exceeds the remaining policy premium, the balance will be refunded). If a reserve is subsequently paid for amount in definition, the paid date becomes the date of the last qualifying loss.

This discount may be combined with any other discount shown in the manual unless otherwise specified. If the insured cannot prove a certified claim history containing the data necessary to determine loss free eligibility, the loss free discount will be applied at the underwriter's discretion.

New to Company Credit

An insured may be eligible for a New to Company Credit pursuant to the following guidelines:

a. Never insured with the Company, or
b. Previously insured with Company more than 3 years ago.

Credit in the amount of 15% of filed manual rates shall apply to the insureds first, second and third consecutive years of coverage.

This credit is not subject to the aggregate credit rule and subject to underwriting guidelines. Only one request for this credit program will be granted to an eligible insured during any period of time insured by the Company.

Endorsed Carrier Discount Program

The Company may be named as the endorsed carrier for a program (which could include, but is not limited to, specialty societies and provider networks). In return, the Company will grant each participant in the program a discount of 5%.

This discount may be combined with any other discount shown in the manual unless otherwise specified.

This discount may not be combined with the Hospital Staff Groups/Medical Groups Discount. This discount may be combined with the Expense Savings Discount in the case where the Expense Savings Discount is higher than the Endorsed Carrier Discount. The combined discount under the two programs will be capped at the Expense Savings Discount.

Expense Savings Discount Program

These discounts will be applied to the sum of individual insureds premiums. All physicians must be insured.

This discount is not applicable to tail rates.

This discount can be combined with any other discount, unless otherwise specified.

Size of Group	Discount
2 to 4 physicians	2.5%
5 to 9 physicians	5.0%
10 to 19 physicians	7.5%
20 or more physicians	10.0%

Risk Management Discount Program

An insured may receive a 5% discount for:

- Participation in company sponsored or approved risk management workshops or in-office seminars

This discount is not applicable to tail rates.

This discount can be combined with any other discount, unless otherwise specified.

Elite Physician Program

A physician may receive a 5% discount at renewal if they meet all of the following guidelines:

- Board certification in area of specialization.
- Five years of practice history in area of specialization.
- Certification through the United States Medical Licensing Exam (USMLE) if a physician was trained outside the United States. The physician must also have completed a residency and/or fellowship program in the United States.
- Certification by the Liaison Committee on Medical Education (LCME). He or she must also have completed a residency and/or fellowship program in the United States.
- Three years of continuous coverage with the Company.
- No history of impairment or substance abuse.
- No crimes committed, other than minor traffic violations.
- No incident (unless closed without any payment), including notice of a claim, claim tendered, incurred, or paid indemnity or allocated loss adjustment expense incurred or paid, and medical board actions reported to current or previous insurer, validated by a company generated loss run and/or sworn statement signed by the physician/group.
- No material change of risk including a change in specialty, geographic change or practice pattern from time policy is issued through renewal.

This discount can be combined with any other discount, unless otherwise specified.

Base Rate and Rating Factors

Base Rate	$25,909

Class Relativity Factors

Class	Relativity
0A	0.3650
0B	0.5600
0C	0.6500
0D	0.7000
0E	0.8000
0F	0.8500
0	0.9000
1	1.0000
1A	1.1000
1B	1.1500
1C	1.2000
1D	1.2500
1E	1.3000
1F	1.3500
1G	1.5000
1H	1.6500
2	1.7500
2A	1.9000
2B	2.0000
2C	2.2500
2D	2.5000
3	2.7500
3A	3.0000
3B	3.2500
3C	3.5000
4	3.7500
4A	4.0000
4B	4.2500
4C	4.5000
5	4.7500
5A	5.0000
5B	5.2500
5C	5.5000
6	5.7500
6A	5.8000
7	6.7500
7A	7.7500
8	8.5000
Chir Asst	0.0402
NMW-Share Corp	0.4125
NMW-Share Phys	0.2063
NP-Share Corp	0.0825
NP-Share Phys	0.0413
PA-Share Corp	0.0825
PA-Share Phys	0.0413

Allied Healthcare Relativity Factors
(for separate limits)

Class	Relativity
Nurse Practitioner	0.110
Physicians Assistant	0.110
Nurse Anesthetist	0.220
Nurse Midwife	1.100
Optometrist	0.055

Increased Limit Factors

Policy Limit	(d)
100K/300K	0.500
200K/600K	0.600
250K/750K	0.650
500K/1,500K	0.727
1,000K/1,000K	0.950
1,000K/3,000K	1.000
2,000K/5,000K	1.350
3,000K/6,000K	1.554

Claims Made Factors

Maturity	
1	0.250
2	0.500
3	0.780
4	0.925
Mature	1.000

Territory Factors

Territory	Factor	Description
1	1.000	Cook, Jackson, Madison, St. Clair and Will counties
2	0.900	Vermilion county
3	0.860	Kane, McHenry and Winnebago counties
4	0.810	Kanakee and Lake counties
5	0.710	Bureau, Champaign, Coles, DeKalb, DuPage, Effingham, LaSalle, Macon, Ogle and Randolph counties
6	0.670	Grundy county
7	0.470	Adams, Knox, Peoria and Rock Island counties
8	0.570	Sangamom county
9	0.520	Remainder of State

Specialty Classification Listing	No Surgery	Minor Surgery	Surgery	Other
Abdominal			3B	
Allergy				0B
Anesthesiology				1F
Anesthesiology / Pain Management				1G
Broncho-Esophagology				0
Cardiovascular Disease – Interventional		2		
Cardiovascular Disease – Invasive		2		
Cardiology / Cardiovascular Disease	1C	2	4B	
Chiropractor	0A			
Colon & Rectal			2C	
Dermatology – All Other	0D	0		
Dermatopathology	0D	0		
Emergency Medicine		2B		
Endocrinology / Diabetes	0E	1C	2B	
Family/General Practice	1A	2A	2D	
Forensic Medicine	0B			
Gastroenterology	1G	1H	1H	
General Preventive Med – All Other	0C			
General Preventative Med – Aerospace Med	0C			
General Preventative Med – Occupational Med	0C			
General Preventative Med – Public Health	0C			
General Surgery			3B	
Geriatrics	0	1C	2C	
Gynecology	1C	2B	2C	
Hand Surgery			2C	
Head and Neck Surgery			2C	
Hematology / Oncology / Neoplastic Disease	1A	1G	2C	
Hospitalist				1F
Hypnosis	0			
Infectious Disease	1D	1G		
Intensive Care Medicine				2
Internal Medicine	1E	2		
Maternal Fetal Medicine				1
Neonatology			3	
Nephrology	1A	1G	2C	
Neuro-Otology			4C	
Neurology	1G	2	7A	
Not in Active Practice	0		1	
Nuclear Medicine	1			
Nutrition	0B			
OB and OB/Gyn			5	
Opthalmology	0E	1A	1F	0E
Oral or Maxillofacial			2B	
Oral or Maxillofacial (incl. Plastic)			2D	
Orthopedic Surgery (Incl. Spine)			5	
Orthopedic Surgery (No Spine)			3B	
Otorhinolaryngology	0C	1H	2B	
Palliative / Hospice Care	0			
Pathology	0E	0		
Pediatrics	0E	1H		
Pharmacology – Clinical	1			
Physical Medicine & Rehab	0C			
Physical Medicine & Rehab – Pain Management				0C
Physician Doing Liposuction				3
Physicians – NOC	1	1H	3B	
Plastic – ENT			3A	
Plastic Surgery			3B	
Podiatrist	0B	1F	1G	
Psychiatry / Psychoanalysis	0E			
Pulmonary Diseases	1G			
Radiology – Diagnostic				1F
Radiology – Interventional				2B
Radiology – Therapeutic (Radiation Oncology)				1C
Rheumatology	0E			
Sleep Medicine				0
Thoracic			4B	
Traumatic			5	
Urgent Care	1F	1G		
Urogynecology				2A
Urological			2A	
Vascular			4C	

Specialties not listed should be submitted to the Company for classification.

MedMal Direct Insurance Company
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General Rules

Binding Authority and Policy Effective Date

Coverage will not be bound until a properly completed application has been received and approved by the Company. Only the Company may bind coverage or issue Proof of Coverage.

The earliest effective date coverage can be bound will be the date the application is received by the Company. Under no circumstances will coverage be issued prior to the date the applicant was licensed to practice medicine.

The Company will make all determinations of acceptability of coverage.

Policy Period

The policy is typically issued for an annual term. Rates for periods shorter or longer than one (1) year are pro-rated from the annual rate. Exceptions to this rule may appear elsewhere in this manual.

Rates

Rates are determined using the Base Rate and Rating Factors section included in this manual and are a product of the Base Rate, class factor, territory factor, claims made factor and limit factor. Specialties are listed for each rate class in accordance with the Specialty Classification Listing section included in this manual.

If two or more classifications apply to the same physician, the classification with the higher rate will apply. Additionally, if the physician's practice is in two or more territories, the territory with the highest rate will apply. The Company will review such classification and territory designations for exceptions if they involve a minimal portion of the physician's practice. Each such case must be individually submitted for consideration.

The Specialty Classification Listing section included in this manual may not be all inclusive. In some cases, certain procedures deemed to be of higher risk may result in a different classification.

General Rules – continued

Premium Calculations

The premium is rounded to the nearest whole dollar and the premium applicable to each classification or miscellaneous charge is determined by the retroactive date and the policy effective date. The premium is determined by the number of years the retroactive date precedes the effective year.

If the retroactive month/day does not coincide with the policy effective date, the premium retroactive year is determined by the number of days between the two. If the retroactive month/day is 183 days (or less) before the effective month/day, use the effective month/day to determine the retroactive year premium to be used. If the retroactive month/day is 184 days (or more) before the effective month/day, use the prior year to determine the retroactive year premium.

Certain coverages may have an individual retroactive date. These are Corporation Coverage and Allied Healthcare Professional Coverage. Rates for these coverages are determined by their individual retroactive dates.

Premiums apply for each individual on the policy, and for each miscellaneous charge which might apply to that individual.

Endorsement changes will be rated in accordance with the rates in effect at the inception date of the policy or renewal being amended. “Tails” will be issued at the rates in effect at the time of cancellation of the policy.

Limit Changes

Changes in the limit of liability require a signed request by the physician. No change can be made until the request has been received by the Company, and will be effective on the date received unless a later date is specified.

All limit changes are retroactive as respects future claims from incidents which the insured was not aware might result in a claim, as of the effective date of the change. An acknowledgement of this will be sent to the insured to be signed and returned to use for every limit decrease.

Increased limits are subject to Company approval.

General Rules – continued

Cancellations

Unless a policy is cancelled as of inception or anniversary, the return premium will be computed on the basis of 90% pro rata of the unearned premium. Exceptions: cancellations at the request of the Company~~, with a thirty day notice~~; cancellation of one member of a group with the policy remaining in force; cancellations due to the death of the insured; cancellation due to disability which qualifies for free tail; cancellation when fully retiring.

Prior notification will be provided for any cancellation by the Company. If the policy has been in force for 60 days or less, Thirty days prior notice for cancellation by the Company will be provided unless cancellation is for nonpayment of premium in which case ~~for cause; t~~Ten days prior notice will be provided~~or non-payment of premiums due; ten days prior notice for cancellation due to loss of license to practice medicine~~. If the policy has been in force for over 60 days, Sixty days prior notice for cancellation by the Company will be provided unless cancellation is for nonpayment of premium in which case Ten days prior notice will be provided.

Any request for cancellation by the insured must be signed by the insured, and contain the effective date of cancellation as well as the policy number. Once a policy is issued, failure to pay the initial premium payment~~s~~ due will void a policy without a specific request for cancellation being made. Once a ~~Otherwise~~policy is issued and the initial premium payment has been received and accepted, ~~,~~ the Company ~~is required to~~will provide a ten day advance notice of cancellation which will result in an earned premium charge for the coverage period.

Practice Outside of Illinois

Manual rates contemplate exposure as being derived from professional services rendered within the state. An exception will be allowed when a minimal portion of professional services are provided in another state, as approved by the Company.

Premium Payment Plan

When coverage is approved, the premium will be computed and a quotation forwarded. The policy will be bound and issued when the premium and any other required information has been received by the Company.

Premiums may be paid on an annual basis, or (subject to Company approval) under a Premium Payment Plan.

The Premium Payment Plan offers three options:

OPTION #1 - based on two semiannual payments. The first payment due will be 60% of this total, with the one subsequent payments in the amount of 40% of this total.

OPTION #2 - based on four quarterly payments. The first payment due will be 30% of this total, with the three subsequent payments in the amount of 23.33% of this total.

OPTION #3 - based on ten monthly payments. The first payment due will be 20% of this total, with the nine subsequent payments in the amount of 8.89% of this total.

Other payment plans are also available if requested by the insured. The terms of these other plans will be mutually agreed upon by the parties.

If there are endorsement charges during the policy year, any remaining installments will be adjusted for the amount of the charge, and a new schedule will be issued.

Extended Reporting Period Coverage (Tail)

The availability of "Tail" shall be governed by the terms and conditions of the policy and the following rules contained herein.

A policy canceled at any date after the original inception date is eligible for this coverage. An option to purchase "Tail" coverage will be provided by the Company, as part of the cancellation processing. Thirty days will be provided in the option period; after this period has expired, the coverage will no longer be available.

"Tail" processing is handled by the Company, based on the current filed rates in effect at the time of cancellation. The ERE factor shown below is applied to the mature claims made rate. Physicians between maturity years will be pro-rated.

Maturity	ERE Factor
1	0.850
2	1.450
3	1.800
4	1.900
Mature	2.000

When purchased, "Tail" coverage will be subject to an experience rating plan based on the claim experience of the prior active coverage as of the effective date of cancellation. The total payments and reserves for indemnity and loss adjustment expenses at the time of cancellation will be divided by the total liability premium paid to the company while insured, to determine the experience factor to be applied to the tail charge.

Loss Ratio	Experience Factor
Less than 100%	1.000
100% to 125%	1.100
125% to 150%	1.200
150% to 175%	1.300
175% to 200%	1.400
More than 200%	1.500

Exception: "Tail" coverage will be provided at no additional charge to any insured:

1. upon termination of coverage under this policy by reason of death,
2. upon termination of coverage under this policy by reason of total and permanent disability from the practice of medicine, or
3. upon termination of coverage under this policy by reason of permanent and complete retirement from the practice of medicine after being continuously insured under a medical professional liability policy for at least five years immediately preceding retirement and being continuously insured by the Company for at least one year immediately preceding retirement.

Only the following discounts will apply to the calculation of ERE premiums: Loss Free, Part-Time Practice Discount; New Physician Discount; Optional Coverage Discounts; Sabbatical/Leave of Absence; Deductible. All surcharges will apply to the calculation of ERE premiums.

Locum Tenens Coverage

If temporary coverage is required for a physician providing substitute coverage for an insured, a locum tenens policy may be issued or limited coverage may be added to the insured's policy by endorsement.

A potential locum tenens must submit an application for underwriting review and be licensed to practice medicine in the same state as the insured physician. The locum tenens must be employed by and providing temporary coverage for one of our insureds.

Upon approval, an option will be offered to issue on the following:

1. Endorse the insured's policy to cover ONLY professional services rendered on behalf of our insured physician for the time period specified. There will be a shared limit of liability, and no premium charge will apply. No individual "tail" coverage is available.

   This endorsement is limited ONLY to situations where a locum tenens is replacing an insured who will not be otherwise practicing during the coverage period. A signed option form must be on file for this option.

2. An individual policy will be issued for the employee, and then canceled on a pro-rata basis. Lump-sum "tail" coverage will be issued on a pro-rata basis for the coverage term. The policy and "tail" coverage must be paid in full. Under this option, the "tail" coverage is not optional.

Coverage under this rule will not be in effect for more than 180 consecutive days.

Premium Adjustment for Class or Territory Change

When an individual changes to a different classification or territory, there is a continuing exposure to claims from the prior class or territory. In order to provide for this continuing exposure, one of two rating methods shall be used. The methodology used will be determined at the discretion of the insured.

1. The rates of the two classifications or territories will be blended together using the number of days in the coverage period as the weight for each classification or territory. All credits and/or surcharges that would have applied if the change had not been made will continue to apply. If an extended reporting period (tail) is elected, the appropriate ERE Factor will be applied to the prior and current classification and then blended to determine the “tail” premium. All other rules for extended reporting period (tail) coverage apply.

2. A form of “tail” charge shall be applied.

   The charge will be based on the difference between the “tail” charge for the old classification and the new classification. It will be computed utilizing the “tail” rates and procedures in effect on the effective date of the policy or renewal being changed.

   The original retroactive date will be maintained for the new classification and/or territory. If the policy subsequently canceled, any “tail” premium applicable will be based only on the new classification and/or territory plus any remaining premium due for the change adjustment.

   If an insured becomes eligible under the terms of the policy for free “tail” coverage, any remaining charge for the change adjustment will also be considered within the terms of the free “tail” coverage.

   An insured who is already eligible for free “tail” coverage upon full retirement, may reduce to a lower classification without a premium adjustment.

Coverage Form

All coverages are written on a claims-made basis. All new policies will be issued with a retroactive date equal to the coverage effective date, unless the applicant is approved for Prior Acts Coverage. This coverage is provided by the use of a retroactive date prior to the new coverage effective date and is subject to specific approval by the Company.

Allied Healthcare Professional Coverage

Allied Healthcare Professional Coverage is available for certified Physician's Assistants, Nurse Anesthetists, Nurse Practitioners, and Nurse Midwives who are employed by our insured. The Allied Healthcare Professional will be specifically named on the policy and coverage may apply on a shared limit, separate limit or vicarious basis.

This coverage is required for employed certified Physician's Assistants, Nurse Anesthetists, Nurse Practitioners, and Nurse Midwives; or they must provide proof of individual coverage which specifies limits of liability greater than or equal to the same limits carried by the employer. If they are not listed on the Company's Coverage Summary as named insureds and do not have approved coverage elsewhere, the insured is not covered for any liability for the actions of such an employee.

Applications are required for each Allied Healthcare Professional and should be provided to the Company before the employee begins working for the insured. As is the case with physician applicants, each application is subject to prior approval by the Company before the coverage may be added. Coverage cannot be effective prior to receipt of notification.

The rates applicable to Allied Healthcare Professionals, along with the definitions of the rate categories are included in the Base Rate and Rating Factors section included in this manual.

A charge will apply for the employers' vicarious liability for each employee of the insured who does not have coverage on an individual MDIC policy. Charges for the vicarious liability are based on the allied healthcare professional's specialty and will be rated as 10% of the premium applicable if the allied healthcare professional had been insured with the Company with a separate limit of liability.

CompliancePro tector Coverage

CompliancePro tector Coverage is included as part of the medical professional liability premium and pays defense costs for covered proceedings (as defined in policy form) instituted by a regulatory or administrative body arising out of an insureds professional practice.

Limit per Physician: $50,000 per covered proceeding / $100,000 annual aggregate

Deductible: $1,000 per covered proceeding

Group Aggregate: A Group Aggregate Limit for Medicare/Medicaid also applies to groups and is determined based on the size of the group per the following table:

Group Size	Group Annual Aggregate
2 - 4	$100,000
5 – 9	$150,000
10 – 19	$200,000
20+	$250,000

CyberProtector Coverage

CyberProtector Coverage is included as part of the medical professional liability premium and pays for network related exposures arising out of an insureds professional practice.

Limit per Physician:

Multimedia Liability	$50,000 per claim
Security and Privacy Liability	$50,000 per claim
Privacy Regulatory Defense and Penalties	$50,000 per claim
Privacy Breach Response Costs, Patient Notification Expenses, and Patient Support and Credit Monitoring Costs	$50,000 per claim
Network Asset Protection	$50,000 per claim
Cyber Extortion	$50,000 per claim
Cyber Terrorism	$50,000 per claim

Aggregate per Physician: $50,000 annual aggregate

Group Aggregate: A Group Aggregate Limit for and is determined based on the size of the group per the following table:

Group Size	Group Annual Aggregate
1	$50,000
2 – 9	$100,000
10 – 24	$150,000
25+	$250,000

New Physician Discount

A new physician is a physician who is:

1. entering the first year of private practice following:

    a. completion of residency or a fellowship program in their specialty; or

    b. periods of obligatory payback in a military, university or government setting.

    A physician qualifying as a new physician may have up to one (1) year of employment after the completion of residency before being disqualified. We will not issue any prior acts coverage for this employment period.

2. an experienced physician who completes a residency or fellowship program in a different specialty and re-enters private practice in that different specialty.

Applicable Discounts

1. A 50% discount applies to first year claims made rates. This discount replaces any other applicable discount, except Deductibles. This discount may not be used if prior acts coverage applies.

2. A 30% discount applies to second year claims made rates.

3. A 15% discount applies to third year claims made rates.

Thereafter, standard rates apply. Loss Free Discounts may not be applied if a physician is receiving a New Physician Discount. Other discounts or surcharges may be applied in the second and third years of coverage.

Part-Time Practice Rate Discount

A physician will receive a part-time rate only if:

1. Practice does not exceed 1,000 hours per year for Part-Time, or 500 hours per year for Quarter-Time. The approximate practice time must be determined and will include the time the physician spends in patient care (including hospital rounds, completion of medical records, and consultations)

2. The part time practice is permanent, or of a long-term duration of at least one year, except for pregnancy. Maternity leave will be for at least three months and not to exceed twelve months.

Annual verification of eligibility is required, along with any special documentation which the Company may deem necessary. Policies issued under this rule will be written with the following discount applied to the annual premium otherwise applicable:

New policies with no prior acts coverage: 50% discount for Part-Time
75% discount for Quarter-Time

New policies with Prior acts coverage:

1. If the part-time start date is the same as the retroactive date, 50% discount for Part-Time or 75% discount for Quarter-Time.
2. If the part-time start date is after the retroactive date, the applicable discount will follow the schedule listed below for current insureds.

Current Insureds:

When a current insured becomes eligible for a part-time rate mid-term, the existing policy will be endorsed to reflect the appropriate discount.

Rates will be phased in over a period of time to reflect a premium adjustment for continued exposure of the prior acts practice activity. If the insured has been with the Company long enough to qualify for free tail if retired, the 50% discount for Part-Time or 75% discount for Quarter-Time discount will apply.

The discount applicable will be determined by the number of years at the part time activity per the following table:

	Part-Time	Quarter-Time
First year	15%	20%
Second year	30%	40%
Third Year	50%	75%

Sabbatical/Leave of Absence

A physician is provided premium relief when taking a leave of absence (including pregnancy, disability or continuing education) or a sabbatical when it exceeds 45 days. It cannot be used for vacation time.

To determine eligibility, the Company requires a signed statement from the insured stating the reason for the leave, the starting date and the anticipated ending date.

Discount for eligible physicians: 50% for all classes.

If the physician is receiving a New Physicians discount of 15% or 30%, that discount will be removed and replaced with the 50% discount above.

If a New Physician discount of 50% is being applied, the 50% discount will not apply.

If the physician is in his/her 1st or 2nd year of Part-Time practice (receiving 15% or 30% discount, respectively), the Part-Time discount will be removed and replaced with the 50% discount above. If the physician is in his/her 3rd or more year of Part-Time practice (receiving a 50% discount), the Part-Time discount will be removed and replaced with the 50% discount above. A Loss Free discount, if applicable, will still apply.

If the physician is in his/her 1st or 2nd year of Quarter-Time practice (receiving 20% or 40% discount, respectively), the Quarter-Time discount will be removed and replaced with the 50% discount above. If the physician is in his/her 3rd or more year of Quarter-Time practice (receiving a 75% discount), the Quarter-Time discount will be reduced to 25% and the 50% discount above will be added for a total discount of 75%. A Loss Free discount, if applicable, will still apply.

The classification and discounts will be returned to their original status upon notification of return to practice. No premium adjustment will be charged for this period of time.

Military Deployment

The Company will provide a temporary suspension of premiums during the period of deployment for physicians who are called to active duty. Eligible physicians must submit copies of their orders at the onset of the deployment and upon return to practice. Calculation of premium credit will be determined by the actual number of days deployed.

Corporation Coverage

Optional coverage with a separate limit of liability for a professional association, corporation or partnership is available.

If all physicians members' (shareholders or partners) are not insured by the Company, they may be added to the corporate coverage schedule, subject to underwriting approval, upon proof of acceptable individual coverage at the same limit (or higher) as the corporate limit. Otherwise, there is no corporate coverage for their actions. Charges for the vicarious liability are based on the physicians' specialty and will be rated as 10% of the premium applicable if the physician had been insured with the Company.

Ancillary personnel are covered under the corporate coverage as long as they are acting within the scope of their employment, even if working with an individual physician not included in the physician schedule.

Employed physicians insured elsewhere may be added to the schedule of physicians included in the corporate coverage with appropriate proof of other insurance (as is currently required). In this case, the usual vicarious liability charge will not apply; they will be rated as if they were insured physicians.

Charges for Allied Healthcare Professionals and other vicarious liability charges will be added to the corporate coverage on the same basis as is currently required.

Retroactive coverage for the corporate coverage can be considered. If approved; the same affidavit used for individual coverage will be used for the corporate coverage. The affidavit must be signed by the President or other authorized officer of the organization applying for the coverage. If all members (including employed physicians) do not have the same limit of liability individually, the limit available for the organization is the lowest limit of any individual physician scheduled.

RATES:

Coverage is calculated as a percentage of the physician premium. If the physician rate is discounted or surcharged, the final rate will be used to determine the charge.

Group Size	
1 physician	20.0%
2 - 4 physicians	15.0%
5 – 9 physicians	12.0%
10 – 19 physicians	9.0%
20 – 49 physicians	7.0%
50+ physicians	5.0%

If the retroactive date of the optional corporate coverage is later than the physician retroactive date, the physician rate for corporate coverage will be recomputed based on the corporate retroactive date for purposes of determining the corporate charge. If the scheduled physician is not insured with the Company, the corporate charge is based on the charge which would apply if insured by us.

Retrospective Rating Plan

Eligibility

The retrospective rating plan period is the one-year period beginning with the effective date of the Policy that is the subject of the Retrospective Premium Endorsement.

This rating plan is available to those insureds whose Standard Premium exceeds $1,000,000 per year. The rating elements will be defined in the Retrospective Rating Endorsement and on the remainder of this page.

Retrospective Premium Formula. The retrospective premium will be the sum of the Basic Premium plus the Excess Premium plus the product of the Incurred Losses times the Loss Conversion Factor, times the Tax Multiplier, subject to the Maximum and Minimum premium as described herein. Therefore, the retrospective premium shall be calculated by the following formula:

$$[BP + EP + (IL \times LCF)] \times TM$$

BP = Basic Premium = Basic Premium Factor x Standard Premium
EP = Excess Premium = Excess Premium Factor x Standard Premium
LCF = Loss Conversion Factor
IL = Incurred Losses
TM = Tax Multiplier

Retrospective Rating Plan Factors	
Policy Limit	Factor
Basic premium factor	0.264
Excess premium factor	0.200
Loss conversion factor	1.000
Tax multiplier	1.026
Minimum premium factor	0.476
Maximum premium factor	1.250

The Standard Premium is the total premium collected by the Company during the Plan year and is the premium that we would charge during the Plan year for the insurance subject to the retrospective rating if the retrospective premium rating had not been chosen (manual premium minus applicable discounts and/or credits).

Incurred losses means (1) all paid losses; plus (2) reserved losses as determined by us; (3) allocated loss adjustment expenses paid including but not limited to expenses associated with premiums on bonds, attorney fees, expert witness fees, court costs and interest payable in accordance with the provisions of the policy; plus (4) allocated loss adjustment expenses reserved as determined by us; plus (5) expenses incurred in seeking recovery against a third party.

Maximum and Minimum Premium. The Retrospective Premium will not be less than the Minimum Premium or more than the Maximum Premium.

Retrospective Rating Plan (continued)

First and Subsequent Retrospective Premium Adjustments. We will calculate the retrospective premium using all Incurred Losses we have as of (180) one hundred and eighty days after the rating plan period ends and, if necessary, annually thereafter. With respect to the loss limitation element, for each claim that remains open, it shall be assumed that the actual loss will equal the maximum possible loss limit for that claim for the purposes of calculating the retrospective premium adjustment. If the above calculation results in a premium that is less than amounts previously billed, then we will promptly pay any return premium adjustments that are due. If the above calculation results in a premium that is greater than amounts previously billed, then you shall make payment to us within (30) days.

Final Retrospective Premium Adjustment. The retrospective premium will be adjusted annually as described above until: (1) all claims have been closed; or (2) the paid losses and paid allocated loss adjustment expense used in the retrospective premium calculation causes the retrospective premium to equal the Maximum Premium. Notwithstanding any final calculation, we reserve the right to adjust the retroactive premium in the event that a closed claim is subsequently subject to Incurred Losses. In such event, you shall make payment to us within (30) thirty days for any such Incurred Losses subject to the loss limitation provision set forth in the Retrospective Premium Endorsement.

Paid Extended Reporting Period Endorsements. Paid extended reporting period endorsements shall not be eligible for retrospective rating and shall not be construed as being part of the Retrospective Premium Endorsement.

Special Valuation. We may make a special valuation based on the Retrospective Premium Formula contained herein as of any date that you are declared bankrupt or insolvent, make an assignment for the benefit of creditors, or are involved in reorganization, receivership, or liquidation.

Recovery From Others. We have your rights to recover all advances and payments, including those within the loss limitation amount, from anyone liable for the Incurred Losses. You will do everything necessary to protect those rights for us and to help us enforce them. If we recover any payment made under the Retrospective Premium Endorsement from anyone liable for Incurred Losses the amount we recover (after deducting from such recovery the expenses incurred in effecting such recovery paid by us) will first be applied to any payments made by us in excess of the loss limitation payments made by you. The remainder of the recovery, if any, will be credited against the amounts paid or reimbursed to you in accordance with the retrospective premium calculation.

Cancellation of Policy. If the Policy that is the subject of the Retrospective Premium Endorsement is cancelled, the effective date of cancellation will become the end of the retrospective rating period. If we cancel for nonpayment of premium, the Standard Premium shall become the applicable premium for the Policy notwithstanding the Retrospective Premium Endorsement, which shall ~~be deemed null and void~~no longer apply, and a pro rata refund of the unearned premium, less a ten percent (10%) cancellation charge, shall be returned. If you cancel, the Standard Premium for the rating period will be calculated according to the short rate cancellation procedure under the Policy. This premium will be the Minimum Premium and will be used to determine the Basic Premium. This Minimum Premium will also be used to determine the Excess Premium. The Maximum Premium will be based on the Standard Premium for the rating plan period, increased pro rata to 365 days.

Optional Coverage Discounts

A policyholder may elect to have the policy endorsed for any or all of the following and will receive the applicable discount:

~~Defense Expenses Within Limits – A 5% discount will apply when a policy is endorsed to include payment of loss adjustment and defense expenses within the limits of liability.~~

Punitive Damage Exclusion – A 5% discount will apply when a policy is endorsed to exclude punitive damages coverage.

Waiver of Consent to Settle – A 5% discount will apply when a policy is endorsed to waive the right to consent to settle a claim and give the Company the sole right to investigate, negotiate and settle.

These discounts will be applied to the individual physicians or surgeons liability premiums.

Hospital Medical Staff Groups/Medical Groups

A Hospital Medical Staff Group is eligible for the premium discounts shown below. Coverage will be provided by issuing a policy which provides individual limits for each physician. Physicians currently insured will be eligible to enter a group program at their individual anniversary date. Each group may elect to have a common renewal date or allow the members to maintain their anniversary dates. If a common anniversary date is elected and the physician is entering at a date other than the Group effective date, new business and converting business will be issued a short term policy to expire on the anniversary date of the group. The rates in effect at the time of the effective date of the group shall apply to all individuals entering during that one-year period.

Group Discount	5%

This discount may not be combined with any Endorsed Carrier Discount or Expense Savings Discount plan.

“Refer to Company” Rating Rule

If an individual risk, before the application of any filed credits/debits, develops an annual premium of at least $100,000 at $1,000,000/$3,000,000 limits and such individual risk presents exposures or hazards different from those contemplated in the rates, rules and coverages filed on behalf of the Company, the otherwise applicable rates, rules and coverages may be modified accordingly. However, The Company shall maintain compliance with all Illinois laws and rules for any risk rated under this rule including maintaining all supporting documentation and completing all reporting in accordance with applicable state statutes and regulations.

Claim Surcharge Program

The premium applicable to those physicians who have experienced more than two "chargeable" claims over a period of five (5) years may be surcharged in accordance with the following table:

2 chargeable claims	50% surcharge
3 chargeable claims	150% surcharge
4 or more chargeable claims	500% surcharge

"Chargeable Claim" as it applies to this rule is defined as: any indemnity payment over $50,000 or any indemnity reserve of $100,000 or more. Each and every claim shall have a determination of whether or not it is "chargeable".

Schedule Rating Program

The Company has determined that significant variability exists in the hazards faced by physicians engaged in the practice of medicine.

Exposure conditions vary with respect to:

Exposure Condition	Credit	Debit
Qualifications/Training/Continuing Education, Experience, including: • Board Eligibility or Board Certification • Hospital Affiliations or Staff Privileges • Experience in Specialty • Accreditation • Cumulative years of patient experience	20%	20%
Practice Structure/Patterns (including, but not limited to: practice profile; practice stability; practice size; patient load; support staff; managed care network participation)	20%	20%
Risk Management (including, but not limited to: use of software; acceptance of specialty practice guides; employment of qualified risk manager, record-keeping practices; credentialing; quality assurance programs; peer review)	20%	20%
Employee selection, supervision, training and experience	5%	5%
Compliance with applicable regulations (OSHA, CLIA, etc.)	5%	5%
Cooperation with Underwriting/Claims/Defense Counsel	5%	5%

In recognition of these factors, the Company will apply a debit or credit to the otherwise applicable rate based upon the underwriter's overall evaluation of the risk.

The maximum credit will be ~~50~~25%
The maximum debit will be ~~50~~25%

Slot Rating

Coverage for a multi-physician group is available on a Slot Rating basis. Under this method, positions are covered rather than specific individuals and coverage will be provided on a shared limit basis. Since the Slot is continuous, individuals who depart the Slot will be able to report claims that occurred while they were part of the Slot. In the event a Slot is eliminated, an Extended Reporting endorsement for that Slot may be purchased for the Slot based on the applicable retroactive date, classification, territory, and limits. Individuals who depart the Slot may purchase, within 30 days of their departure, individual Extended Reporting Period Coverage based on the classification and territory of the Slot and based on the individual's Beginning Date, instead of Retroactive Date, and Departure Date, instead of cancellation date. The applicable manual slot rate will be determined by the classification of the Slot and will be allocated based upon the most appropriate of the following methods:

1. Full Time Equivalency – The Full Time Equivalency (FTE) is based on the total number of hours of medical practice per year that the Slot will be covering. The definition of one FTE is 2,500 hours per year. The minimum FTE assigned to any Slot is no less than 1.0.

2. Patient Visit Equivalency – The Patient Visit Equivalency (PVE) is based on the number of patient visits per year to be covered by the Slot. The number of patient visits equivalent to a physician year is based on the following:

Emergency Medicine:	5,400 visits per year
Urgent Care:	7,500 visits per year
Outpatient Clinic:	10,000 visits per year

For specialties not listed above, the number of patient visits equivalent to a physician year is 2,500 hours times the applicable rate of visits per hour. The rate of visits per hour is derived from the group's historical experience, subject to a minimum rate of 1 visit per hour and a maximum rate of 3 visits per hour. The minimum PVE assigned to any Slot is no less than 1.0.

The Slot's Annual Aggregate limit is determined based on the number of FTE or PVE:

FTE/PVE	Annual Aggregate
1	3 x the per incident limit
2	5 x the per incident limit
3	7 x the per incident limit
4 or more	9 x the per incident limit

The FTE's and annual visits reported to the Company for rating purposes are subject to audit, at the Company's discretion. Discounts for new physicians, part time or loss free cannot be used in conjunction with this rating rule.

Vicarious Liability for Supervision of Nurse Midwives (not employed by the insured)

For an additional charge of 5% of the premium for each nurse midwife supervised the Company will provide coverage within your existing limits of liability to cover the vicarious exposure.

Additionally, each nurse midwife must furnish evidence of insurance which specifies limits of liability greater than or equal to the same limits carried by the supervising physician.

Deductibles

Deductibles may apply to either damages (indemnity) or to damages and defense (indemnity and ALAE). The Deductibles listed below have no annual aggregate. If an annual aggregate is desired, the risk should be submitted for rating.

The Company will advance any deductibles due to the plaintiff. We will require reimbursement from the named insured within 30 days of notification that such amounts have been paid. The Company's liability to pay damages under the policy will be reduced by any applicable deductible(s).

	Credit for Indemnity Only	**Credit for Indemnity & ALAE**
	Policy Limits	Policy Limits
Deductible	1M / 3M	1M / 3M
$5,000	2.5%	6.5%
$10,000	4.5%	11.5%
$15,000	6.0%	15.0%
$20,000	8.0%	17.5%
$25,000	9.0%	20.0%
$50,000	15.0%	30.5%
$75,000	20.5%	36.0%
$100,000	25.0%	40.0%
$150,000	32.0%	47.0%
$200,000	37.5%	55.0%
$250,000	42.0%	58.0%

The above rate reduction factors apply to the respective policy limit rates in order to determine the appropriate deductible rate reduction. Factors for limits not shown on this table shall be determined by linear interpolation.

Loss Free Discount Program

Any physician, who is loss free as of the original effective date of new coverage, or the renewal date of current coverage, will qualify for the following discounts:

Loss Free Years	Discount
0	None
1	2.0%
2	4.0%
3	6.0%
4	8.0%
5	10.0%
6	12.0%
7	14.0%
8	16.0%
9	18.0%
10 or more	20.0%

Loss free status will be determined on Illinois experience only and will start as of the year Illinois practice commenced. The number of loss free years is calculated from the latter of: (1) January 1 of the year Illinois practice began or (2) the payment date of the last qualifying loss, to the physician's renewal date.

Exception: If a physician is relocating to Illinois from another state and can provide proof of continuous insurance coverage as well as a certified claim history, then the qualified loss free years will be accepted.

"Loss" as it applies to this rule is defined as: Any indemnity payment over $50,000, or any indemnity reserve of $100,000 or more. The number of loss free years is 0 if there is an indemnity reserve of $100,000 or more.

If loss free status changes between the time the renewal is issued and the actual effective date, the renewal will be reissued at the correct premium charge and the difference billed to the insured.

If a loss occurs during the year, the loss free status reverts to 0 years. However, the loss free credit will only change at renewal. In the event a reserve of $100,000 or more is subsequently settled for less than amount in definition, an endorsement will be issued to reflect all credits which were lost due to the reserve amount (if the credit exceeds the remaining policy premium, the balance will be refunded). If a reserve is subsequently paid for amount in definition, the paid date becomes the date of the last qualifying loss.

This discount may be combined with any other discount shown in the manual unless otherwise specified. If the insured cannot prove a certified claim history containing the data necessary to determine loss free eligibility, the loss free discount will be applied at the underwriter's discretion.

New to Company Credit

An insured may be eligible for a New to Company Credit pursuant to the following guidelines:

a. Never insured with the Company, or
b. Previously insured with Company more than 3 years ago.

Credit in the amount of 15% of filed manual rates shall apply to the insureds first, second and third consecutive years of coverage.

This credit is not subject to the aggregate credit rule and subject to underwriting guidelines. Only one request for this credit program will be granted to an eligible insured during any period of time insured by the Company.

Endorsed Carrier Discount Program

The Company may be named as the endorsed carrier for a program (which could include, but is not limited to, specialty societies and provider networks). In return, the Company will grant each participant in the program a discount of 5%.

This discount may be combined with any other discount shown in the manual unless otherwise specified.

This discount may not be combined with the Hospital Staff Groups/Medical Groups Discount. This discount may be combined with the Expense Savings Discount in the case where the Expense Savings Discount is higher than the Endorsed Carrier Discount. The combined discount under the two programs will be capped at the Expense Savings Discount.

Expense Savings Discount Program

These discounts will be applied to the sum of individual insureds premiums. All physicians must be insured.

This discount is not applicable to tail rates.

This discount can be combined with any other discount, unless otherwise specified.

Size of Group	Discount
2 to 4 physicians	2.5%
5 to 9 physicians	5.0%
10 to 19 physicians	7.5%
20 or more physicians	10.0%

Risk Management Discount Program

An insured may receive a 5% discount for:

- Participation in company sponsored or approved risk management workshops or in-office seminars

This discount is not applicable to tail rates.

This discount can be combined with any other discount, unless otherwise specified.

Elite Physician Program

A physician may receive a 5% discount at renewal if they meet all of the following guidelines:

- Board certification in area of specialization.
- Five years of practice history in area of specialization.
- Certification through the United States Medical Licensing Exam (USMLE) if a physician was trained outside the United States. The physician must also have completed a residency and/or fellowship program in the United States.
- Certification by the Liaison Committee on Medical Education (LCME). He or she must also have completed a residency and/or fellowship program in the United States.
- Three years of continuous coverage with the Company.
- No history of impairment or substance abuse.
- No crimes committed, other than minor traffic violations.
- No incident (unless closed without any payment), including notice of a claim, claim tendered, incurred, or paid indemnity or allocated loss adjustment expense incurred or paid, and medical board actions reported to current or previous insurer, validated by a company generated loss run and/or sworn statement signed by the physician/group.
- No material change of risk including a change in specialty, geographic change or practice pattern from time policy is issued through renewal.

This discount can be combined with any other discount, unless otherwise specified.

Base Rate and Rating Factors

Base Rate	$25,909

Class Relativity Factors

Class	Relativity
0A	0.3650
0B	0.5600
0C	0.6500
0D	0.7000
0E	0.8000
0F	0.8500
0	0.9000
1	1.0000
1A	1.1000
1B	1.1500
1C	1.2000
1D	1.2500
1E	1.3000
1F	1.3500
1G	1.5000
1H	1.6500
2	1.7500
2A	1.9000
2B	2.0000
2C	2.2500
2D	2.5000
3	2.7500
3A	3.0000
3B	3.2500
3C	3.5000
4	3.7500
4A	4.0000
4B	4.2500
4C	4.5000
5	4.7500
5A	5.0000
5B	5.2500
5C	5.5000
6	5.7500
6A	5.8000
7	6.7500
7A	7.7500
8	8.5000
Chir Asst	0.0402
NMW-Share Corp	0.4125
NMW-Share Phys	0.2063
NP-Share Corp	0.0825
NP-Share Phys	0.0413
PA-Share Corp	0.0825
PA-Share Phys	0.0413

Allied Healthcare Relativity Factors
(for separate limits)

Class	Relativity
Nurse Practitioner	0.110
Physicians Assistant	0.110
Nurse Anesthetist	0.220
Nurse Midwife	1.100
Optometrist	0.055

Increased Limit Factors

Policy Limit	(d)
100K/300K	0.500
200K/600K	0.600
250K/750K	0.650
500K/1,500K	0.727
1,000K/1,000K	0.950
1,000K/3,000K	1.000
2,000K/5,000K	1.350
3,000K/6,000K	1.554

Claims Made Factors

Maturity	
1	0.250
2	0.500
3	0.780
4	0.925
Mature	1.000

Territory Factors

Territory	Factor	Description
1	1.000	Cook, Jackson, Madison, St. Clair and Will counties
2	0.900	Vermilion county
3	0.860	Kane, McHenry and Winnebago counties
4	0.810	Kanakee and Lake counties
5	0.710	Bureau, Champaign, Coles, DeKalb, DuPage, Effingham, LaSalle, Macon, Ogle and Randolph counties
6	0.670	Grundy county
7	0.470	Adams, Knox, Peoria and Rock Island counties
8	0.570	Sangamom county
9	0.520	Remainder of State

Specialty Classification Listing	No Surgery	Minor Surgery	Surgery	Other
Abdominal			3B	
Allergy				0B
Anesthesiology				1F
Anesthesiology / Pain Management				1G
Broncho-Esophagology				0
Cardiovascular Disease – Interventional		2		
Cardiovascular Disease – Invasive		2		
Cardiology / Cardiovascular Disease	1C	2	4B	
Chiropractor	0A			
Colon & Rectal			2C	
Dermatology – All Other	0D	0		
Dermatopathology	0D	0		
Emergency Medicine		2B		
Endocrinology / Diabetes	0E	1C	2B	
Family/General Practice	1A	2A	2D	
Forensic Medicine	0B			
Gastroenterology	1G	1H	1H	
General Preventive Med – All Other	0C			
General Preventative Med – Aerospace Med	0C			
General Preventative Med – Occupational Med	0C			
General Preventative Med – Public Health	0C			
General Surgery			3B	
Geriatrics	0	1C	2C	
Gynecology	1C	2B	2C	
Hand Surgery			2C	
Head and Neck Surgery			2C	
Hematology / Oncology / Neoplastic Disease	1A	1G	2C	
Hospitalist				1F
Hypnosis	0			
Infectious Disease	1D	1G		
Intensive Care Medicine				2
Internal Medicine	1E	2		
Maternal Fetal Medicine				1
Neonatology			3	
Nephrology	1A	1G	2C	
Neuro-Otology			4C	
Neurology	1G	2	7A	
Not in Active Practice	0		1	
Nuclear Medicine	1			
Nutrition	0B			
OB and OB/Gyn			5	
Opthalmology	0E	1A	1F	0E
Oral or Maxillofacial			2B	
Oral or Maxillofacial (incl. Plastic)			2D	
Orthopedic Surgery (Incl. Spine)			5	
Orthopedic Surgery (No Spine)			3B	
Otorhinolaryngology	0C	1H	2B	
Palliative / Hospice Care	0			
Pathology	0E	0		
Pediatrics	0E	1H		
Pharmacology – Clinical	1			
Physical Medicine & Rehab	0C			
Physical Medicine & Rehab – Pain Management				0C
Physician Doing Liposuction				3
Physicians – NOC	1	1H	3B	
Plastic – ENT			3A	
Plastic Surgery			3B	
Podiatrist	0B	1F	1G	
Psychiatry / Psychoanalysis	0E			
Pulmonary Diseases	1G			
Radiology – Diagnostic				1F
Radiology – Interventional				2B
Radiology – Therapeutic (Radiation Oncology)				1C
Rheumatology	0E			
Sleep Medicine				0
Thoracic			4B	
Traumatic			5	
Urgent Care	1F	1G		
Urogynecology				2A
Urological			2A	
Vascular			4C	

Specialties not listed should be submitted to the Company for classification.

SERFF Tracking #:	*MERL-129004724*	***State Tracking #:***		***Company Tracking #:***	*MERL-129004724*

State:	*Illinois*	***Filing Company:***	*MedMal Direct Insurance Company*
TOI/Sub-TOI:	*11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons*		
Product Name:	*MMDIC IL Initial Rates Filing*		
Project Name/Number:	*/*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
04/29/2013		Supporting Document	Manual	03/27/2014	MDIC-IL-RateManual (01-2014).pdf (Superceded)

MedMal Direct Insurance Company
Underwriting Rates and Rules Manual - Illinois

General Rules

Binding Authority and Policy Effective Date

Coverage will not be bound until a properly completed application has been received and approved by the Company. Only the Company may bind coverage or issue Proof of Coverage.

The earliest effective date coverage can be bound will be the date the application is received by the Company. Under no circumstances will coverage be issued prior to the date the applicant was licensed to practice medicine.

The Company will make all determinations of acceptability of coverage.

Policy Period

The policy is typically issued for an annual term. Rates for periods shorter or longer than one (1) year are pro-rated from the annual rate. Exceptions to this rule may appear elsewhere in this manual.

Rates

Rates are determined using the Base Rate and Rating Factors section included in this manual and are a product of the Base Rate, class factor, territory factor, claims made factor and limit factor. Specialties are listed for each rate class in accordance with the Specialty Classification Listing section included in this manual.

If two or more classifications apply to the same physician, the classification with the higher rate will apply. Additionally, if the physician's practice is in two or more territories, the territory with the highest rate will apply. The Company will review such classification and territory designations for exceptions if they involve a minimal portion of the physician's practice. Each such case must be individually submitted for consideration.

The Specialty Classification Listing section included in this manual may not be all inclusive. In some cases, certain procedures deemed to be of higher risk may result in a different classification.

General Rules – continued

Premium Calculations

The premium is rounded to the nearest whole dollar and the premium applicable to each classification or miscellaneous charge is determined by the retroactive date and the policy effective date. The premium is determined by the number of years the retroactive date precedes the effective year.

If the retroactive month/day does not coincide with the policy effective date, the premium retroactive year is determined by the number of days between the two. If the retroactive month/day is 183 days (or less) before the effective month/day, use the effective month/day to determine the retroactive year premium to be used. If the retroactive month/day is 184 days (or more) before the effective month/day, use the prior year to determine the retroactive year premium.

Certain coverages may have an individual retroactive date. These are Corporation Coverage and Allied Healthcare Professional Coverage. Rates for these coverages are determined by their individual retroactive dates.

Premiums apply for each individual on the policy, and for each miscellaneous charge which might apply to that individual.

Endorsement changes will be rated in accordance with the rates in effect at the inception date of the policy or renewal being amended. “Tails” will be issued at the rates in effect at the time of cancellation of the policy.

Limit Changes

Changes in the limit of liability require a signed request by the physician. No change can be made until the request has been received by the Company, and will be effective on the date received unless a later date is specified.

All limit changes are retroactive as respects future claims from incidents which the insured was not aware might result in a claim, as of the effective date of the change. An acknowledgement of this will be sent to the insured to be signed and returned to use for every limit decrease.

Increased limits are subject to Company approval.

General Rules – continued

Cancellations

Unless a policy is cancelled as of inception or anniversary, the return premium will be computed on the basis of 90% pro rata of the unearned premium. Exceptions: cancellations at the request of the Company, with a thirty day notice; cancellation of one member of a group with the policy remaining in force; cancellations due to the death of the insured; cancellation due to disability which qualifies for free tail; cancellation when fully retiring.

Prior notification will be provided for any cancellation by the Company. Thirty days prior notice for cancellation by the Company for cause; ten days prior notice or non-payment of premiums due; ten days prior notice for cancellation due to loss of license to practice medicine.

Any request for cancellation by the insured must be signed by the insured, and contain the effective date of cancellation as well as the policy number. Once a policy is issued, failure to pay premiums due will void a policy without a specific request for cancellation being made. Otherwise, the Company is required to provide a ten day advance notice of cancellation which will result in an earned premium charge for the coverage period.

Practice Outside of Illinois

Manual rates contemplate exposure as being derived from professional services rendered within the state. An exception will be allowed when a minimal portion of professional services are provided in another state, as approved by the Company.

Premium Payment Plan

When coverage is approved, the premium will be computed and a quotation forwarded. The policy will be bound and issued when the premium and any other required information has been received by the Company.

Premiums may be paid on an annual basis, or (subject to Company approval) under a Premium Payment Plan.

The Premium Payment Plan offers three options:

OPTION #1 - based on two semiannual payments. The first payment due will be 60% of this total, with the one subsequent payments in the amount of 40% of this total.

OPTION #2 - based on four quarterly payments. The first payment due will be 30% of this total, with the three subsequent payments in the amount of 23.33% of this total.

OPTION #3 - based on ten monthly payments. The first payment due will be 20% of this total, with the nine subsequent payments in the amount of 8.89% of this total.

Other payment plans are also available if requested by the insured. The terms of these other plans will be mutually agreed upon by the parties.

If there are endorsement charges during the policy year, any remaining installments will be adjusted for the amount of the charge, and a new schedule will be issued.

Extended Reporting Period Coverage (Tail)

The availability of "Tail" shall be governed by the terms and conditions of the policy and the following rules contained herein.

A policy canceled at any date after the original inception date is eligible for this coverage. An option to purchase "Tail" coverage will be provided by the Company, as part of the cancellation processing. Thirty days will be provided in the option period; after this period has expired, the coverage will no longer be available.

"Tail" processing is handled by the Company, based on the current filed rates in effect at the time of cancellation. The ERE factor shown below is applied to the mature claims made rate. Physicians between maturity years will be pro-rated.

Maturity	ERE Factor
1	0.850
2	1.450
3	1.800
4	1.900
Mature	2.000

When purchased, "Tail" coverage will be subject to an experience rating plan based on the claim experience of the prior active coverage as of the effective date of cancellation. The total payments and reserves for indemnity and loss adjustment expenses at the time of cancellation will be divided by the total liability premium paid to the company while insured, to determine the experience factor to be applied to the tail charge.

Loss Ratio	Experience Factor
Less than 100%	1.000
100% to 125%	1.100
125% to 150%	1.200
150% to 175%	1.300
175% to 200%	1.400
More than 200%	1.500

Exception: "Tail" coverage will be provided at no additional charge to any insured:

1. upon termination of coverage under this policy by reason of death,
2. upon termination of coverage under this policy by reason of total and permanent disability from the practice of medicine, or
3. upon termination of coverage under this policy by reason of permanent and complete retirement from the practice of medicine after being continuously insured under a medical professional liability policy for at least five years immediately preceding retirement and being continuously insured by the Company for at least one year immediately preceding retirement.

Only the following discounts will apply to the calculation of ERE premiums: Loss Free, Part-Time Practice Discount; New Physician Discount; Optional Coverage Discounts; Sabbatical/Leave of Absence; Deductible. All surcharges will apply to the calculation of ERE premiums.

Locum Tenens Coverage

If temporary coverage is required for a physician providing substitute coverage for an insured, a locum tenens policy may be issued or limited coverage may be added to the insured's policy by endorsement.

A potential locum tenens must submit an application for underwriting review and be licensed to practice medicine in the same state as the insured physician. The locum tenens must be employed by and providing temporary coverage for one of our insureds.

Upon approval, an option will be offered to issue on the following:

1. Endorse the insured's policy to cover ONLY professional services rendered on behalf of our insured physician for the time period specified. There will be a shared limit of liability, and no premium charge will apply. No individual "tail" coverage is available.

   This endorsement is limited ONLY to situations where a locum tenens is replacing an insured who will not be otherwise practicing during the coverage period. A signed option form must be on file for this option.

2. An individual policy will be issued for the employee, and then canceled on a pro-rata basis. Lump-sum "tail" coverage will be issued on a pro-rata basis for the coverage term. The policy and "tail" coverage must be paid in full. Under this option, the "tail" coverage is not optional.

Coverage under this rule will not be in effect for more than 180 consecutive days.

Premium Adjustment for Class or Territory Change

When an individual changes to a different classification or territory, there is a continuing exposure to claims from the prior class or territory. In order to provide for this continuing exposure, one of two rating methods shall be used. The methodology used will be determined at the discretion of the insured.

1. The rates of the two classifications or territories will be blended together using the number of days in the coverage period as the weight for each classification or territory. All credits and/or surcharges that would have applied if the change had not been made will continue to apply. If an extended reporting period (tail) is elected, the appropriate ERE Factor will be applied to the prior and current classification and then blended to determine the “tail” premium. All other rules for extended reporting period (tail) coverage apply.

2. A form of “tail” charge shall be applied.

   The charge will be based on the difference between the “tail” charge for the old classification and the new classification. It will be computed utilizing the “tail” rates and procedures in effect on the effective date of the policy or renewal being changed.

   The original retroactive date will be maintained for the new classification and/or territory. If the policy subsequently canceled, any “tail” premium applicable will be based only on the new classification and/or territory plus any remaining premium due for the change adjustment.

   If an insured becomes eligible under the terms of the policy for free “tail” coverage, any remaining charge for the change adjustment will also be considered within the terms of the free “tail” coverage.

   An insured who is already eligible for free “tail” coverage upon full retirement, may reduce to a lower classification without a premium adjustment.

Coverage Form

All coverages are written on a claims-made basis. All new policies will be issued with a retroactive date equal to the coverage effective date, unless the applicant is approved for Prior Acts Coverage. This coverage is provided by the use of a retroactive date prior to the new coverage effective date and is subject to specific approval by the Company.

Allied Healthcare Professional Coverage

Allied Healthcare Professional Coverage is available for certified Physician's Assistants, Nurse Anesthetists, Nurse Practitioners, and Nurse Midwives who are employed by our insured. The Allied Healthcare Professional will be specifically named on the policy and coverage may apply on a shared limit, separate limit or vicarious basis.

This coverage is required for employed certified Physician's Assistants, Nurse Anesthetists, Nurse Practitioners, and Nurse Midwives; or they must provide proof of individual coverage which specifies limits of liability greater than or equal to the same limits carried by the employer. If they are not listed on the Company's Coverage Summary as named insureds and do not have approved coverage elsewhere, the insured is not covered for any liability for the actions of such an employee.

Applications are required for each Allied Healthcare Professional and should be provided to the Company before the employee begins working for the insured. As is the case with physician applicants, each application is subject to prior approval by the Company before the coverage may be added. Coverage cannot be effective prior to receipt of notification.

The rates applicable to Allied Healthcare Professionals, along with the definitions of the rate categories are included in the Base Rate and Rating Factors section included in this manual.

A charge will apply for the employers' vicarious liability for each employee of the insured who does not have coverage on an individual MDIC policy. Charges for the vicarious liability are based on the allied healthcare professional's specialty and will be rated as 10% of the premium applicable if the allied healthcare professional had been insured with the Company with a separate limit of liability.

CompliancePro tector Coverage

CompliancePro tector Coverage is included as part of the medical professional liability premium and pays defense costs for covered proceedings (as defined in policy form) instituted by a regulatory or administrative body arising out of an insureds professional practice.

Limit per Physician: $50,000 per covered proceeding / $100,000 annual aggregate

Deductible: $1,000 per covered proceeding

Group Aggregate: A Group Aggregate Limit for Medicare/Medicaid also applies to groups and is determined based on the size of the group per the following table:

Group Size	Group Annual Aggregate
2 - 4	$100,000
5 – 9	$150,000
10 – 19	$200,000
20+	$250,000

CyberProtector Coverage

CyberProtector Coverage is included as part of the medical professional liability premium and pays for network related exposures arising out of an insureds professional practice.

Limit per Physician:

Multimedia Liability	$50,000 per claim
Security and Privacy Liability	$50,000 per claim
Privacy Regulatory Defense and Penalties	$50,000 per claim
Privacy Breach Response Costs, Patient Notification Expenses, and Patient Support and Credit Monitoring Costs	$50,000 per claim
Network Asset Protection	$50,000 per claim
Cyber Extortion	$50,000 per claim
Cyber Terrorism	$50,000 per claim

Aggregate per Physician: $50,000 annual aggregate

Group Aggregate: A Group Aggregate Limit for and is determined based on the size of the group per the following table:

Group Size	Group Annual Aggregate
1	$50,000
2 – 9	$100,000
10 – 24	$150,000
25+	$250,000

New Physician Discount

A new physician is a physician who is:

1. entering the first year of private practice following:

    a. completion of residency or a fellowship program in their specialty; or

    b. periods of obligatory payback in a military, university or government setting.

    A physician qualifying as a new physician may have up to one (1) year of employment after the completion of residency before being disqualified. We will not issue any prior acts coverage for this employment period.

2. an experienced physician who completes a residency or fellowship program in a different specialty and re-enters private practice in that different specialty.

Applicable Discounts

1. A 50% discount applies to first year claims made rates. This discount replaces any other applicable discount, except Deductibles. This discount may not be used if prior acts coverage applies.

2. A 30% discount applies to second year claims made rates.

3. A 15% discount applies to third year claims made rates.

Thereafter, standard rates apply. Loss Free Discounts may not be applied if a physician is receiving a New Physician Discount. Other discounts or surcharges may be applied in the second and third years of coverage.

Part-Time Practice Rate Discount

A physician will receive a part-time rate only if:

1. Practice does not exceed 1,000 hours per year for Part-Time, or 500 hours per year for Quarter-Time. The approximate practice time must be determined and will include the time the physician spends in patient care (including hospital rounds, completion of medical records, and consultations)

2. The part time practice is permanent, or of a long-term duration of at least one year, except for pregnancy. Maternity leave will be for at least three months and not to exceed twelve months.

Annual verification of eligibility is required, along with any special documentation which the Company may deem necessary. Policies issued under this rule will be written with the following discount applied to the annual premium otherwise applicable:

New policies with no prior acts coverage: 50% discount for Part-Time
75% discount for Quarter-Time

New policies with Prior acts coverage:

1. If the part-time start date is the same as the retroactive date, 50% discount for Part-Time or 75% discount for Quarter-Time.
2. If the part-time start date is after the retroactive date, the applicable discount will follow the schedule listed below for current insureds.

Current Insureds:

When a current insured becomes eligible for a part-time rate mid-term, the existing policy will be endorsed to reflect the appropriate discount.

Rates will be phased in over a period of time to reflect a premium adjustment for continued exposure of the prior acts practice activity. If the insured has been with the Company long enough to qualify for free tail if retired, the 50% discount for Part-Time or 75% discount for Quarter-Time discount will apply.

The discount applicable will be determined by the number of years at the part time activity per the following table:

	Part-Time	Quarter-Time
First year	15%	20%
Second year	30%	40%
Third Year	50%	75%

Sabbatical/Leave of Absence

A physician is provided premium relief when taking a leave of absence (including pregnancy, disability or continuing education) or a sabbatical when it exceeds 45 days. It cannot be used for vacation time.

To determine eligibility, the Company requires a signed statement from the insured stating the reason for the leave, the starting date and the anticipated ending date.

Discount for eligible physicians: 50% for all classes.

If the physician is receiving a New Physicians discount of 15% or 30%, that discount will be removed and replaced with the 50% discount above.

If a New Physician discount of 50% is being applied, the 50% discount will not apply.

If the physician is in his/her 1st or 2nd year of Part-Time practice (receiving 15% or 30% discount, respectively), the Part-Time discount will be removed and replaced with the 50% discount above. If the physician is in his/her 3rd or more year of Part-Time practice (receiving a 50% discount), the Part-Time discount will be removed and replaced with the 50% discount above. A Loss Free discount, if applicable, will still apply.

If the physician is in his/her 1st or 2nd year of Quarter-Time practice (receiving 20% or 40% discount, respectively), the Quarter-Time discount will be removed and replaced with the 50% discount above. If the physician is in his/her 3rd or more year of Quarter-Time practice (receiving a 75% discount), the Quarter-Time discount will be reduced to 25% and the 50% discount above will be added for a total discount of 75%. A Loss Free discount, if applicable, will still apply.

The classification and discounts will be returned to their original status upon notification of return to practice. No premium adjustment will be charged for this period of time.

Military Deployment

The Company will provide a temporary suspension of premiums during the period of deployment for physicians who are called to active duty. Eligible physicians must submit copies of their orders at the onset of the deployment and upon return to practice. Calculation of premium credit will be determined by the actual number of days deployed.

Corporation Coverage

Optional coverage with a separate limit of liability for a professional association, corporation or partnership is available.

If all physicians members' (shareholders or partners) are not insured by the Company, they may be added to the corporate coverage schedule, subject to underwriting approval, upon proof of acceptable individual coverage at the same limit (or higher) as the corporate limit. Otherwise, there is no corporate coverage for their actions. Charges for the vicarious liability are based on the physicians' specialty and will be rated as 10% of the premium applicable if the physician had been insured with the Company.

Ancillary personnel are covered under the corporate coverage as long as they are acting within the scope of their employment, even if working with an individual physician not included in the physician schedule.

Employed physicians insured elsewhere may be added to the schedule of physicians included in the corporate coverage with appropriate proof of other insurance (as is currently required). In this case, the usual vicarious liability charge will not apply; they will be rated as if they were insured physicians.

Charges for Allied Healthcare Professionals and other vicarious liability charges will be added to the corporate coverage on the same basis as is currently required.

Retroactive coverage for the corporate coverage can be considered. If approved; the same affidavit used for individual coverage will be used for the corporate coverage. The affidavit must be signed by the President or other authorized officer of the organization applying for the coverage. If all members (including employed physicians) do not have the same limit of liability individually, the limit available for the organization is the lowest limit of any individual physician scheduled.

RATES:

Coverage is calculated as a percentage of the physician premium. If the physician rate is discounted or surcharged, the final rate will be used to determine the charge.

Group Size	
1 physician	20.0%
2 - 4 physicians	15.0%
5 – 9 physicians	12.0%
10 – 19 physicians	9.0%
20 – 49 physicians	7.0%
50+ physicians	5.0%

If the retroactive date of the optional corporate coverage is later than the physician retroactive date, the physician rate for corporate coverage will be recomputed based on the corporate retroactive date for purposes of determining the corporate charge. If the scheduled physician is not insured with the Company, the corporate charge is based on the charge which would apply if insured by us.

Retrospective Rating Plan

Eligibility

The retrospective rating plan period is the one-year period beginning with the effective date of the Policy that is the subject of the Retrospective Premium Endorsement.

This rating plan is available to those insureds whose Standard Premium exceeds $1,000,000 per year. The rating elements will be defined in the Retrospective Rating Endorsement and on the remainder of this page.

Retrospective Premium Formula. The retrospective premium will be the sum of the Basic Premium plus the Excess Premium plus the product of the Incurred Losses times the Loss Conversion Factor, times the Tax Multiplier, subject to the Maximum and Minimum premium as described herein. Therefore, the retrospective premium shall be calculated by the following formula:

$$[BP + EP + (IL \times LCF)] \times TM$$

BP = Basic Premium = Basic Premium Factor x Standard Premium
EP = Excess Premium = Excess Premium Factor x Standard Premium
LCF = Loss Conversion Factor
IL = Incurred Losses
TM = Tax Multiplier

Retrospective Rating Plan Factors	
Policy Limit	Factor
Basic premium factor	0.264
Excess premium factor	0.200
Loss conversion factor	1.000
Tax multiplier	1.026
Minimum premium factor	0.476
Maximum premium factor	1.250

The Standard Premium is the total premium collected by the Company during the Plan year and is the premium that we would charge during the Plan year for the insurance subject to the retrospective rating if the retrospective premium rating had not been chosen (manual premium minus applicable discounts and/or credits).

Incurred losses means (1) all paid losses; plus (2) reserved losses as determined by us; (3) allocated loss adjustment expenses paid including but not limited to expenses associated with premiums on bonds, attorney fees, expert witness fees, court costs and interest payable in accordance with the provisions of the policy; plus (4) allocated loss adjustment expenses reserved as determined by us; plus (5) expenses incurred in seeking recovery against a third party.

Maximum and Minimum Premium. The Retrospective Premium will not be less than the Minimum Premium or more than the Maximum Premium.

Retrospective Rating Plan (continued)

First and Subsequent Retrospective Premium Adjustments. We will calculate the retrospective premium using all Incurred Losses we have as of (180) one hundred and eighty days after the rating plan period ends and, if necessary, annually thereafter. With respect to the loss limitation element, for each claim that remains open, it shall be assumed that the actual loss will equal the maximum possible loss limit for that claim for the purposes of calculating the retrospective premium adjustment. If the above calculation results in a premium that is less than amounts previously billed, then we will promptly pay any return premium adjustments that are due. If the above calculation results in a premium that is greater than amounts previously billed, then you shall make payment to us within (30) days.

Final Retrospective Premium Adjustment. The retrospective premium will be adjusted annually as described above until: (1) all claims have been closed; or (2) the paid losses and paid allocated loss adjustment expense used in the retrospective premium calculation causes the retrospective premium to equal the Maximum Premium. Notwithstanding any final calculation, we reserve the right to adjust the retroactive premium in the event that a closed claim is subsequently subject to Incurred Losses. In such event, you shall make payment to us within (30) thirty days for any such Incurred Losses subject to the loss limitation provision set forth in the Retrospective Premium Endorsement.

Paid Extended Reporting Period Endorsements. Paid extended reporting period endorsements shall not be eligible for retrospective rating and shall not be construed as being part of the Retrospective Premium Endorsement.

Special Valuation. We may make a special valuation based on the Retrospective Premium Formula contained herein as of any date that you are declared bankrupt or insolvent, make an assignment for the benefit of creditors, or are involved in reorganization, receivership, or liquidation.

Recovery From Others. We have your rights to recover all advances and payments, including those within the loss limitation amount, from anyone liable for the Incurred Losses. You will do everything necessary to protect those rights for us and to help us enforce them. If we recover any payment made under the Retrospective Premium Endorsement from anyone liable for Incurred Losses the amount we recover (after deducting from such recovery the expenses incurred in effecting such recovery paid by us) will first be applied to any payments made by us in excess of the loss limitation payments made by you. The remainder of the recovery, if any, will be credited against the amounts paid or reimbursed to you in accordance with the retrospective premium calculation.

Cancellation of Policy. If the Policy that is the subject of the Retrospective Premium Endorsement is cancelled, the effective date of cancellation will become the end of the retrospective rating period. If we cancel for nonpayment of premium, the Standard Premium shall become the applicable premium for the Policy notwithstanding the Retrospective Premium Endorsement, which shall be deemed null and void, and a pro rata refund of the unearned premium, less a ten percent (10%) cancellation charge, shall be returned. If you cancel, the Standard Premium for the rating period will be calculated according to the short rate cancellation procedure under the Policy. This premium will be the Minimum Premium and will be used to determine the Basic Premium. This Minimum Premium will also be used to determine the Excess Premium. The Maximum Premium will be based on the Standard Premium for the rating plan period, increased pro rata to 365 days.

Optional Coverage Discounts

A policyholder may elect to have the policy endorsed for any or all of the following and will receive the applicable discount:

Defense Expenses Within Limits – A 5% discount will apply when a policy is endorsed to include payment of loss adjustment and defense expenses within the limits of liability.

Punitive Damage Exclusion – A 5% discount will apply when a policy is endorsed to exclude punitive damages coverage.

Waiver of Consent to Settle – A 5% discount will apply when a policy is endorsed to waive the right to consent to settle a claim and give the Company the sole right to investigate, negotiate and settle.

These discounts will be applied to the individual physicians or surgeons liability premiums.

Hospital Medical Staff Groups/Medical Groups

A Hospital Medical Staff Group is eligible for the premium discounts shown below. Coverage will be provided by issuing a policy which provides individual limits for each physician. Physicians currently insured will be eligible to enter a group program at their individual anniversary date. Each group may elect to have a common renewal date or allow the members to maintain their anniversary dates. If a common anniversary date is elected and the physician is entering at a date other than the Group effective date, new business and converting business will be issued a short term policy to expire on the anniversary date of the group. The rates in effect at the time of the effective date of the group shall apply to all individuals entering during that one-year period.

Group Discount	5%

This discount may not be combined with any Endorsed Carrier Discount or Expense Savings Discount plan.

“Refer to Company” Rating Rule

If an individual risk, before the application of any filed credits/debits, develops an annual premium of at least $100,000 at $1,000,000/$3,000,000 limits and such individual risk presents exposures or hazards different from those contemplated in the rates, rules and coverages filed on behalf of the Company, the otherwise applicable rates, rules and coverages may be modified accordingly. However, The Company shall maintain compliance with all Illinois laws and rules for any risk rated under this rule including maintaining all supporting documentation and completing all reporting in accordance with applicable state statutes and regulations.

Claim Surcharge Program

The premium applicable to those physicians who have experienced more than two "chargeable" claims over a period of five (5) years may be surcharged in accordance with the following table:

2 chargeable claims	50% surcharge
3 chargeable claims	150% surcharge
4 or more chargeable claims	500% surcharge

"Chargeable Claim" as it applies to this rule is defined as: any indemnity payment over $50,000 or any indemnity reserve of $100,000 or more. Each and every claim shall have a determination of whether or not it is "chargeable".

Schedule Rating Program

The Company has determined that significant variability exists in the hazards faced by physicians engaged in the practice of medicine.

Exposure conditions vary with respect to:

Exposure Condition	Credit	Debit
Qualifications/Training/Continuing Education, Experience, including: • Board Eligibility or Board Certification • Hospital Affiliations or Staff Privileges • Experience in Specialty • Accreditation • Cumulative years of patient experience	20%	20%
Practice Structure/Patterns (including, but not limited to: practice profile; practice stability; practice size; patient load; support staff; managed care network participation)	20%	20%
Risk Management (including, but not limited to: use of software; acceptance of specialty practice guides; employment of qualified risk manager, record-keeping practices; credentialing; quality assurance programs; peer review)	20%	20%
Employee selection, supervision, training and experience	5%	5%
Compliance with applicable regulations (OSHA, CLIA, etc.)	5%	5%
Cooperation with Underwriting/Claims/Defense Counsel	5%	5%

In recognition of these factors, the Company will apply a debit or credit to the otherwise applicable rate based upon the underwriter's overall evaluation of the risk.

The maximum credit will be 50%
The maximum debit will be 50%

Slot Rating

Coverage for a multi-physician group is available on a Slot Rating basis. Under this method, positions are covered rather than specific individuals and coverage will be provided on a shared limit basis. Since the Slot is continuous, individuals who depart the Slot will be able to report claims that occurred while they were part of the Slot. In the event a Slot is eliminated, an Extended Reporting endorsement for that Slot may be purchased for the Slot based on the applicable retroactive date, classification, territory, and limits. Individuals who depart the Slot may purchase, within 30 days of their departure, individual Extended Reporting Period Coverage based on the classification and territory of the Slot and based on the individual's Beginning Date, instead of Retroactive Date, and Departure Date, instead of cancellation date. The applicable manual slot rate will be determined by the classification of the Slot and will be allocated based upon the most appropriate of the following methods:

1. Full Time Equivalency – The Full Time Equivalency (FTE) is based on the total number of hours of medical practice per year that the Slot will be covering. The definition of one FTE is 2,500 hours per year. The minimum FTE assigned to any Slot is no less than 1.0.

2. Patient Visit Equivalency – The Patient Visit Equivalency (PVE) is based on the number of patient visits per year to be covered by the Slot. The number of patient visits equivalent to a physician year is based on the following:

Emergency Medicine:	5,400 visits per year
Urgent Care:	7,500 visits per year
Outpatient Clinic:	10,000 visits per year

For specialties not listed above, the number of patient visits equivalent to a physician year is 2,500 hours times the applicable rate of visits per hour. The rate of visits per hour is derived from the group's historical experience, subject to a minimum rate of 1 visit per hour and a maximum rate of 3 visits per hour. The minimum PVE assigned to any Slot is no less than 1.0.

The Slot's Annual Aggregate limit is determined based on the number of FTE or PVE:

FTE/PVE	Annual Aggregate
1	3 x the per incident limit
2	5 x the per incident limit
3	7 x the per incident limit
4 or more	9 x the per incident limit

The FTE's and annual visits reported to the Company for rating purposes are subject to audit, at the Company's discretion. Discounts for new physicians, part time or loss free cannot be used in conjunction with this rating rule.

Vicarious Liability for Supervision of Nurse Midwives (not employed by the insured)

For an additional charge of 5% of the premium for each nurse midwife supervised the Company will provide coverage within your existing limits of liability to cover the vicarious exposure.

Additionally, each nurse midwife must furnish evidence of insurance which specifies limits of liability greater than or equal to the same limits carried by the supervising physician.

Deductibles

Deductibles may apply to either damages (indemnity) or to damages and defense (indemnity and ALAE). The Deductibles listed below have no annual aggregate. If an annual aggregate is desired, the risk should be submitted for rating.

The Company will advance any deductibles due to the plaintiff. We will require reimbursement from the named insured within 30 days of notification that such amounts have been paid. The Company's liability to pay damages under the policy will be reduced by any applicable deductible(s).

	Credit for Indemnity Only	**Credit for Indemnity & ALAE**
	Policy Limits	Policy Limits
Deductible	1M / 3M	1M / 3M
$5,000	2.5%	6.5%
$10,000	4.5%	11.5%
$15,000	6.0%	15.0%
$20,000	8.0%	17.5%
$25,000	9.0%	20.0%
$50,000	15.0%	30.5%
$75,000	20.5%	36.0%
$100,000	25.0%	40.0%
$150,000	32.0%	47.0%
$200,000	37.5%	55.0%
$250,000	42.0%	58.0%

The above rate reduction factors apply to the respective policy limit rates in order to determine the appropriate deductible rate reduction. Factors for limits not shown on this table shall be determined by linear interpolation.

Loss Free Discount Program

Any physician, who is loss free as of the original effective date of new coverage, or the renewal date of current coverage, will qualify for the following discounts:

Loss Free Years	Discount
0	None
1	2.0%
2	4.0%
3	6.0%
4	8.0%
5	10.0%
6	12.0%
7	14.0%
8	16.0%
9	18.0%
10 or more	20.0%

Loss free status will be determined on Illinois experience only and will start as of the year Illinois practice commenced. The number of loss free years is calculated from the latter of: (1) January 1 of the year Illinois practice began or (2) the payment date of the last qualifying loss, to the physician's renewal date.

Exception: If a physician is relocating to Illinois from another state and can provide proof of continuous insurance coverage as well as a certified claim history, then the qualified loss free years will be accepted.

"Loss" as it applies to this rule is defined as: Any indemnity payment over $50,000, or any indemnity reserve of $100,000 or more. The number of loss free years is 0 if there is an indemnity reserve of $100,000 or more.

If loss free status changes between the time the renewal is issued and the actual effective date, the renewal will be reissued at the correct premium charge and the difference billed to the insured.

If a loss occurs during the year, the loss free status reverts to 0 years. However, the loss free credit will only change at renewal. In the event a reserve of $100,000 or more is subsequently settled for less than amount in definition, an endorsement will be issued to reflect all credits which were lost due to the reserve amount (if the credit exceeds the remaining policy premium, the balance will be refunded). If a reserve is subsequently paid for amount in definition, the paid date becomes the date of the last qualifying loss.

This discount may be combined with any other discount shown in the manual unless otherwise specified. If the insured cannot prove a certified claim history containing the data necessary to determine loss free eligibility, the loss free discount will be applied at the underwriter's discretion.

New to Company Credit

An insured may be eligible for a New to Company Credit pursuant to the following guidelines:

a. Never insured with the Company, or
b. Previously insured with Company more than 3 years ago.

Credit in the amount of 15% of filed manual rates shall apply to the insureds first, second and third consecutive years of coverage.

This credit is not subject to the aggregate credit rule and subject to underwriting guidelines. Only one request for this credit program will be granted to an eligible insured during any period of time insured by the Company.

Endorsed Carrier Discount Program

The Company may be named as the endorsed carrier for a program (which could include, but is not limited to, specialty societies and provider networks). In return, the Company will grant each participant in the program a discount of 5%.

This discount may be combined with any other discount shown in the manual unless otherwise specified.

This discount may not be combined with the Hospital Staff Groups/Medical Groups Discount. This discount may be combined with the Expense Savings Discount in the case where the Expense Savings Discount is higher than the Endorsed Carrier Discount. The combined discount under the two programs will be capped at the Expense Savings Discount.

Expense Savings Discount Program

These discounts will be applied to the sum of individual insureds premiums. All physicians must be insured.

This discount is not applicable to tail rates.

This discount can be combined with any other discount, unless otherwise specified.

Size of Group	Discount
2 to 4 physicians	2.5%
5 to 9 physicians	5.0%
10 to 19 physicians	7.5%
20 or more physicians	10.0%

Risk Management Discount Program

An insured may receive a 5% discount for:

- Participation in company sponsored or approved risk management workshops or in-office seminars

This discount is not applicable to tail rates.

This discount can be combined with any other discount, unless otherwise specified.

Elite Physician Program

A physician may receive a 5% discount at renewal if they meet all of the following guidelines:

- Board certification in area of specialization.
- Five years of practice history in area of specialization.
- Certification through the United States Medical Licensing Exam (USMLE) if a physician was trained outside the United States. The physician must also have completed a residency and/or fellowship program in the United States.
- Certification by the Liaison Committee on Medical Education (LCME). He or she must also have completed a residency and/or fellowship program in the United States.
- Three years of continuous coverage with the Company.
- No history of impairment or substance abuse.
- No crimes committed, other than minor traffic violations.
- No incident (unless closed without any payment), including notice of a claim, claim tendered, incurred, or paid indemnity or allocated loss adjustment expense incurred or paid, and medical board actions reported to current or previous insurer, validated by a company generated loss run and/or sworn statement signed by the physician/group.
- No material change of risk including a change in specialty, geographic change or practice pattern from time policy is issued through renewal.

This discount can be combined with any other discount, unless otherwise specified.

Base Rate and Rating Factors

Base Rate	$25,909

Class Relativity Factors

Class	Relativity
0A	0.3650
0B	0.5600
0C	0.6500
0D	0.7000
0E	0.8000
0F	0.8500
0	0.9000
1	1.0000
1A	1.1000
1B	1.1500
1C	1.2000
1D	1.2500
1E	1.3000
1F	1.3500
1G	1.5000
1H	1.6500
2	1.7500
2A	1.9000
2B	2.0000
2C	2.2500
2D	2.5000
3	2.7500
3A	3.0000
3B	3.2500
3C	3.5000
4	3.7500
4A	4.0000
4B	4.2500
4C	4.5000
5	4.7500
5A	5.0000
5B	5.2500
5C	5.5000
6	5.7500
6A	5.8000
7	6.7500
7A	7.7500
8	8.5000
Chir Asst	0.0402
NMW-Share Corp	0.4125
NMW-Share Phys	0.2063
NP-Share Corp	0.0825
NP-Share Phys	0.0413
PA-Share Corp	0.0825
PA-Share Phys	0.0413

Allied Healthcare Relativity Factors
(for separate limits)

Class	Relativity
Nurse Practitioner	0.110
Physicians Assistant	0.110
Nurse Anesthetist	0.220
Nurse Midwife	1.100
Optometrist	0.055

Increased Limit Factors

Policy Limit	(d)
100K/300K	0.500
200K/600K	0.600
250K/750K	0.650
500K/1,500K	0.727
1,000K/1,000K	0.950
1,000K/3,000K	1.000
2,000K/5,000K	1.350
3,000K/6,000K	1.554

Claims Made Factors

Maturity	
1	0.250
2	0.500
3	0.780
4	0.925
Mature	1.000

Territory Factors

Territory	Factor	Description
1	1.000	Cook, Jackson, Madison, St. Clair and Will counties
2	0.900	Vermilion county
3	0.860	Kane, McHenry and Winnebago counties
4	0.810	Kanakee and Lake counties
5	0.710	Bureau, Champaign, Coles, DeKalb, DuPage, Effingham, LaSalle, Macon, Ogle and Randolph counties
6	0.670	Grundy county
7	0.470	Adams, Knox, Peoria and Rock Island counties
8	0.570	Sangamom county
9	0.520	Remainder of State

Specialty Classification Listing	No Surgery	Minor Surgery	Surgery	Other
Abdominal			3B	
Allergy				0B
Anesthesiology				1F
Anesthesiology / Pain Management				1G
Broncho-Esophagology				0
Cardiovascular Disease – Interventional		2		
Cardiovascular Disease – Invasive		2		
Cardiology / Cardiovascular Disease	1C	2	4B	
Chiropractor	0A			
Colon & Rectal			2C	
Dermatology – All Other	0D	0		
Dermatopathology	0D	0		
Emergency Medicine		2B		
Endocrinology / Diabetes	0E	1C	2B	
Family/General Practice	1A	2A	2D	
Forensic Medicine	0B			
Gastroenterology	1G	1H	1H	
General Preventive Med – All Other	0C			
General Preventative Med – Aerospace Med	0C			
General Preventative Med – Occupational Med	0C			
General Preventative Med – Public Health	0C			
General Surgery			3B	
Geriatrics	0	1C	2C	
Gynecology	1C	2B	2C	
Hand Surgery			2C	
Head and Neck Surgery			2C	
Hematology / Oncology / Neoplastic Disease	1A	1G	2C	
Hospitalist				1F
Hypnosis	0			
Infectious Disease	1D	1G		
Intensive Care Medicine				2
Internal Medicine	1E	2		
Maternal Fetal Medicine				1
Neonatology			3	
Nephrology	1A	1G	2C	
Neuro-Otology			4C	
Neurology	1G	2	7A	
Not in Active Practice	0		1	
Nuclear Medicine	1			
Nutrition	0B			
OB and OB/Gyn			5	
Opthalmology	0E	1A	1F	0E
Oral or Maxillofacial			2B	
Oral or Maxillofacial (incl. Plastic)			2D	
Orthopedic Surgery (Incl. Spine)			5	
Orthopedic Surgery (No Spine)			3B	
Otorhinolaryngology	0C	1H	2B	
Palliative / Hospice Care	0			
Pathology	0E	0		
Pediatrics	0E	1H		
Pharmacology – Clinical	1			
Physical Medicine & Rehab	0C			
Physical Medicine & Rehab – Pain Management				0C
Physician Doing Liposuction				3
Physicians – NOC	1	1H	3B	
Plastic – ENT			3A	
Plastic Surgery			3B	
Podiatrist	0B	1F	1G	
Psychiatry / Psychoanalysis	0E			
Pulmonary Diseases	1G			
Radiology – Diagnostic				1F
Radiology – Interventional				2B
Radiology – Therapeutic (Radiation Oncology)				1C
Rheumatology	0E			
Sleep Medicine				0
Thoracic			4B	
Traumatic			5	
Urgent Care	1F	1G		
Urogynecology				2A
Urological			2A	
Vascular			4C	

Specialties not listed should be submitted to the Company for classification.